States • of • Guernsey

BOARD OF HEALTH

WORKING TOWARDS A BETTER HEALTHIER WAY OF LIFE

99th ANNUAL MOH REPORT

and

Fourth ANNUAL REPORT of the DIRECTOR OF PUBLIC HEALTH

Special Theme:

"The health of older Guernsey"

REPORT FOR THE YEAR 1997/98

BOARD OF HEALTH

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STATES OF GUERNSEY

BOARD OF HEALTH

Objectives

To maintain and improve the health of the people of Guernsey and Alderney as cost effectively as possible by within the resource constraints placed upon it by:

- Identifying health needs - now and in the future.
- Planning the future provision of health services to meet these needs.
- Commissioning the provision of these services.
- Ensuring that the quality of health services provided is high and standards are maintained through careful monitoring.
- Ensuring that only appropriate and effective care or treatment is given, by monitoring the outcome of such interventions.
- Listening to the customers in order to understand their needs and working with others so as to best meet these needs.
- Informing people on health matters, promoting a healthy lifestyle and environment.
- Acting as a 'caring neighbour' and considering the environment for future generations.
- Checking that all health services provided are as cost-efficient as possible.
- Promoting managerial and professional excellence within health services.
- Recruiting, training and developing sufficient health care staff to achieve these objectives and valuing the staff and helping them to meet their needs and objectives.

INTRODUCTORY LETTER TO THE BOARD OF HEALTH

October 1998

The President

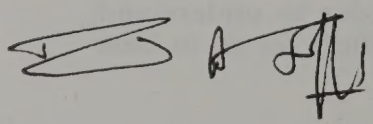
States of Guernsey Board of Health

Sir,

I have pleasure in submitting the 99th Annual Report of the Medical Officer of Health for Guernsey for 1997/1998.

I am, Sir

Your Obedient Servant



Dr David Jeffs

MEDICAL OFFICER OF HEALTH

Director of Public Health

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HIGHLIGHTS FROM THIS REPORT

An extended version of these 'highlights' will be found on the Board of Health 'Home Page', http.//gatekeeper.guernsey.org.uk

- An important function of the Annual MoH Report is to report *'On the state of the Public Health '*. This Report confirms that Guernsey as a whole remains in pretty good health. [p 1]

- However, a significant minority of our population are already middle-aged, and potential problems linked with ageing are likely to become an increasing consideration over the next 20 to 30 years. [p2]

- The 'greying of Guernsey' has implications for housing, healthcare, transport strategy, the provision of pensions, the size of the economically active workforce, and the prosperity and well-being of the island more generally. Providing a public health perspective on these important issues is the 'special theme' of this Report. [Chapter 8 pp 50-78]

- Public health in Guernsey cannot be seen solely from an island perspective however. We need to be aware of, and where appropriate to be influenced by developments on the broader public health front. [p3]

- As well as important new initiatives in public health in Europe, the Blair government has also given public health a new prominence in Britain. This includes the appointment of a Minister for Public Health, the Green Paper *'Our Healthier Nation'*, the White Paper *'The New NHS: Modern, Dependable'*, the introduction of the need for 'clinical governance', and the Chief Medical Officer's Working Party to advise how best to 'strengthen the public health function'. [p4]

- Key themes, including the cost effectiveness of population approaches, the impact of poverty and relative poverty as important determinants of poor health, the need for more intersectoral working, the need to review the function and working together of several States Committees, the benefits of 'evidence based' healthcare, and most importantly the need for local structures of 'clinical governance' are all felt to have special relevance for Guernsey. [pp7/8]

- 'Avoidable ill health' is specifically considered in Chapter 3. Progress in implementing the Guernsey 'tobacco package', developments in addressing alcohol misuse, the Guernsey Drug Strategy, cancer control, a new research project on providing cancer treatment 'far from home' and the establishment of the Guernsey Sexual Health Forum are all detailed. [pp9-22]

- In environmental health, the States of Deliberation have approved significant amendments to existing public health legislation, and have agreed also the introduction of new 'Control of Environmental Pollution' laws. This proposes a legislative framework to control pollution in respect of waste, sea water, noise and air, permitting the introduction of separate Ordinances for each of these. [pp23]

- Food hygiene continues to be a very important aspect of the Environmental Health Department's work. Implementation and education on the recommendations of the Pennington Report on *Ecoli 0157* highlights the need for continuing commitment in this area. [pp24/25]

- With the exception of food poisoning, which still remains a problem, most other notifications of infectious diseases have continued to decline, and again in 1997 are at an historical all time low. [p43]

- The Health Promotion Unit celebrated its 10th birthday in 1998. The past ten years have seen the growth and development of health promotion as a basis for healthier lifestyles into the next millennium. Within its limited resources, the Health Promotion Unit continues to be active and successful in further developing health promotional priorities in the key areas outlined in previous Reports. [p31]

- The need for a comprehensive approach to *'Contraception, Unplanned Pregnancy and Abortion* was outlined in the Policy Letter of that title [Billet d'Etat VIII 1996]. Implementation of the various recommendations approved by the States has led to the appointment of both a part-time co-ordinator, and a qualified counsellor for the Guernsey Family Planning Clinic, which is showing increasing success in meeting the contraceptive needs of its target age group, the young and sexually active. [pp35-37]

- Results are also published of abortions lawfully performed in Guernsey in the first nine months of the controversial Abortion [Guernsey] Law 1997 covering the period March-December 1997. These are further compared with abortions lawfully performed on known Guernsey residents in England and Wales during 1997. The total number of abortions performed during 1997 show no increase above the average number of lawful abortions performed on known Guernsey residents in Britain between 1990-1994. Contrary to fears expressed at the time of the 'Abortion Debate', legalisation of abortion in Guernsey has not yet led to any apparent increase in the total number of terminations performed. [pp38/39]

- Sexual health services are a further important area for future development. Plans are currently being considered regarding comprehensive and more integrated service development in these areas. [pp40/41]

- There have been continuing developments in the fields of Occupational Health, and Fire, Health and Safety with the opening of a specially designed, dedicated Occupational Health suite, and the appointment of a full-time Fire, Health and Safety Advisor. [pp45-49]

- The Report concludes that in relation to the challenge of an ageing population, that Guernsey has 'twelve years to get it right', and that this must include appropriate transport policy, and development of approximately 20-25 new or converted units of 'sheltered housing' annually over the next several years. Although presenting a political and planning challenge, this is felt to be achievable. [pp70-78]

Chapter 1

'On the state of the Public Health.....'

Introduction

England's recently retired Chief Medical Officer, Sir Kenneth Calman, sometimes shows a picture of himself dressed in a white coat, a stethoscope to his ears, with its bell placed firmly on a map of England, somewhere around the East Midlands. He has a quizzical expression on his face, as if trying to make a difficult diagnosis.

He calls the picture 'GP to the Nation'.

It perhaps symbolises the role of the Chief Medical Officer, as England's senior public health physician, to be responsible for and to report *On the state of the Public Health* as the CMO's Annual Report is called.

The Annual Report of the Medical Officer of Health in Guernsey attempts on a lesser scale to fill a similar role. So if Guernsey were a patient, presenting at the doctor's surgery for an annual check up, how would we report 'the health of the Island'?

- *'Generally pretty fit considering .....'.*
- *Could lose a little weight around the middle .....'.*
- *Needs to exercise a lot more .....'.*

Such phrases from the consulting room seem equally applicable to the health of Guernsey's population as a whole. Sociodemographically, the island would seem to have reached a generally comfortable and fairly prosperous middle-age and with this have come many of the problems which will be familiar to those already in their middle years.

But just as in our own personal life, we can make healthier, but sometimes more difficult 'lifestyle choices', so we can as a community try and address some of the issues which evidence suggests are currently impacting adversely on our population's health.

These include diet, levels and opportunities for exercise, patterns and quantities of alcohol consumption, smoking, drugs misuse, sexual health, and necessary action on various environmental factors which may adversely affect human health, both locally and further afield. These several considerations form related themes which are explored in greater depth in Chapter 3.

To continue to progress in these areas requires a number of parallel strategies. These must include:

- Ensuring people have adequate knowledge of factors likely to impact on their own health, sufficient to allow them to make their own personal 'healthy choices' .

- Developing 'healthy public policy' to ensure that 'healthy choices' become 'easy choices'

- Making sure that 'healthy choices' are also 'accessible choices', and particularly that groups such as the less affluent, mothers with children, the elderly, etc do not find themselves excluded from doing what they know is best for their health.

- Making environmental considerations an integral part of both our personal lifestyle choices, and of our wider public health policy.

But just as middle years must inevitably lead on to older age, there is now increasing evidence that the determinants of health in later life are often laid many years before. Action taken now at both a personal and public policy level can do much to ensure that Guernsey is better prepared for the inescapable ageing of our population, which will start to occur in the second and third decades of the next century.

'The health of older Guernsey' and the likely impact of an ageing population on healthcare form the major special theme of this Report. Various aspects of this are explored further in Chapter 8.

To return to our 'patient in the consulting room' metaphor, this year's 'annual check up' confirms that Guernsey as a whole still remains in pretty good health. However, a significant minority of our population is already middle-aged and potential problems linked with ageing are likely to become an increasing consideration over the next twenty to thirty years.

Our best hopes of enjoying a healthier older age as a community will to a large extent depend on what investment we make now in taking those healthier personal lifestyle choices, and implementing the necessary public policies in areas such as healthcare, housing, transport, and planning, together with ensuring there is adequate and equitable funding to support these developments.

Finally, whilst I have attempted whenever possible to acknowledge the many contributors to this Report, it has obviously not been possible, especially in Chapter 8, to recognise every contributor. To all these, and to the many others who have supported public health initiatives throughout the year, my appreciative thanks. I would also wish to specifically thank my personal assistant, Mrs Yvonne Kaill for her help in producing this Report, and to public health data officer, Mrs Jenny Elliott for the production of the several graphs.

Dr David Jeffs
Director of Public Health

Chapter 2

Public Health on the Broader Front

'No man is an island entire of itself'

John Donne 1572-1631

Public Health in the Regional Context

Public Health in Guernsey cannot be seen solely from an island perspective. We need to be aware of, and where appropriate to be influenced by developments on the broader public health front.

The European Commission has recently reviewed the contribution that the Union can make toward promoting public health policy and tackling the medical challenges now facing the fifteen member States. Three broad priorities have been identified:

- Improving information for the development of public health.
- Reacting rapidly to transboundary public health threats.
- Encouraging health promotion and disease prevention.

These approaches will supplement and complement current EU wide programmes in the fields of:

- Combating AIDS and other communicable disease.
- Fighting cancer.
- Tackling drug dependency.
- Promoting health awareness.
- Monitoring health statistics.

Further areas for health action in the EU are likely to include tackling pollution related diseases, injury prevention, and the management of rare diseases within the European framework.

Public Health in Britain

As well as initiatives in Europe, the Blair government in Britain has also given public health a new prominence. The rest of this Chapter will therefore summarise some of the important developments in public health in Britain during 1997-98, and reflect on the importance and possible influence of these on healthcare in Guernsey.

Minister for Public Health

An early sign of the new government's commitment to public health was the appointment of Tessa Jowell as Britain's first Minister for Public Health.

The portfolio of the Minister for Public Health is a broad one, including health education and promotion, nutrition, food hygiene and safety, the environment and health, clinical effectiveness, clinical audit, health outcomes and needs assessment, as well as international health links, including the World Health Organisation, and the EU Health Council.

This commitment to public health approaches is already showing results, with Britain's new support swinging the EU towards a total ban on tobacco advertising and sponsorship, a Food Standards Agency proposed at home, and increased investments in tackling environmental determinants of health, such as air and water quality.

But perhaps the most important development has been the stated commitment by the Minister to create a cross-government public health infra-structure.

Green Paper *'Our Healthier Nation'*

The 'White Paper'- *'The Health of the Nation - A strategy for health in England '* was adopted as health policy by the previous government in July 1992.

Although initially welcomed with enthusiasm, many people working in the field felt that the *'Health of the Nation'* strategy was too *'disease orientated and lifestyle focused'*. There was also an obvious shortfall in the new resources required to achieve the somewhat ambitious objectives.

Consequently, all early priority of the new government was to revisit and reframe the health improvement agenda. This came in the form of a Green Paper *'Our Healthier Nation'* published jointly by the Minister for Health and the Minister for Public Health in February 1998.

Briefly the Green Paper proposed:

- To improve the health of the population as a whole by increasing the length of lives, and the number of years people spend free from illness.

- To improve the health of the worst off in society, and to narrow the health gap.

- To set up a **national contract for better health** involving central government, local communities, and individuals.

- To set quantifiable targets, and by the year 2010 make measurable progress in the areas of:

  - Heart disease and stroke prevention
  - Accident reduction
  - Reducing cancer mortality
  - Reducing deaths from suicide and undetermined injury.

Unlike the *'Health of the Nation'*, *'Our Healthier Nation'* recognised that the health of the public is largely determined by factors outside the NHS. It acknowledges that poverty, unemployment, and social exclusion all contribute to ill health, as does air and water quality and other environmental factors, as well as housing, transport, social services, and the quality of healthcare.

The Green Paper has been widely distributed for comment [including its own Internet site], and generally has received a favourable response. It is expected to be followed by a White Paper towards the end of 1998. Most encouragingly, all indications are that there will be new resources allocated to help achieve these ambitious objectives, and to make *'Our Healthier Nation'* more than just rhetorical 'healthspeak'.

White Paper *'The New NHS: Modern, Dependable'*

Three months before the publication of *'Our Healthier Nation'*, the government had published a White Paper on reform in the NHS, entitled *'The New NHS: Modern: Dependable'*.

Key components of the ten year programme will include:

- **Primary care groups** of GP's responsible for the healthcare of a defined population.

- **Health improvement programmes** to improve healthcare locally.

- A new **National Institute for Clinical Excellence** [NICE] to a give strong lead on clinical and cost effectiveness.

- A new **Commission for Health Improvement** [CHIMP] to support and oversee the quality of clinical services at local levels and to tackle shortcomings.

The three key themes running throughout the White Paper are:

- A focus on improving health on a population basis.
- Promoting and strengthening moves towards more 'evidence based medicine'.
- Through monitoring and **'clinical governance',** to ensure that *'quality is at the Heart'* of all NHS services provided.

What is Clinical Governance?

Briefly, clinical governance is a structured approach to ensure that quality of healthcare is seen as a central objective by all health providers. Performance needs to be judged as much on the quality of services delivered, as on the more traditional indices such as financial accounting outturns.

Clinical governance will be responsible for ensuring:

- That systems that monitor the quality of clinical practice are in place, and are functioning properly.
- That clinical practices are reviewed and improved as a result.
- That clinical practitioners meet standards, such as those set out in *'Good Medical Practice'* issued by the GMC.
- The development of leadership skills amongst clinicians, which will be essential in implementing and furthering 'clinical governance'.

'Strengthening the Public Health Function'

The dual challenges of improving population health, and ensuring quality of services delivered under the NHS requires a robust 'public health function'. Recognising this, the Ministers for Health and Public Health, have jointly commissioned the Chief Medical Officer, Sir Kenneth Calman to set up a Working Party to examine approaches as to how best to 'strengthen the public health function'.

'Public health function' is widely defined, covering the inter-related roles of many agencies, such as local government, voluntary organisations, and universities, as well as the NHS The final Report from the Working Party is still awaited, but key concepts developed during the consultation stage include:

- A wider understanding of health and the determinants of health is essential.
- Better co-ordination is required between public health and clinical services.
- An increase in public health skills and more dedicated public health staff are needed to deliver the government's health strategy agenda.
- Sustained and sustainable development in better health for the public will not be achieved through short term marginal projects.
- Effective joint working at central, regional and local levels will be required.

What is the significance for Guernsey?

1997/98 have obviously been a time of high activity in health policy, health service development and public health.

It was proposed earlier in this Chapter that Guernsey needed to be aware of developments in health and public health elsewhere, and to be influenced by these wherever appropriate. What then are the lessons and implications for Guernsey in this profusion of public health activity now occurring in Britain, and more widely in Europe?

Key themes of importance must include:

- Population approaches are effective and likely to be cost effective. The Board of Health has rightly broadened its remit beyond merely ensuring treatment of ill health, into promoting good health, and tackling the determinants of poor health.
- Poverty and relative poverty are important determinants of poor health. Although Guernsey is an affluent island, there has been relatively little work done in recent years on examining the contribution of poverty and relative poverty towards the burden of illness in Guernsey. One outcome of such an approach might be the focusing of resources where they are likely to achieve the maximum benefit. The benefits of such an approach needs to be examined in the Guernsey context.
- More inter-sectoral working is required. Responsibility for various aspects of health determinants are currently spread across a plethora of States Committees. From the health perspective, this is neither efficient nor effective. There are now welcome signs of key personnel from several States Committees working more effectively together on areas of shared responsibility, such as the President's Policy Group and the Chief Officers' Strategy Group looking at drugs, the Social Policy and the Environmental Strategy Groups both convened by Advisory and Finance, and the Working Party on the Provision and Funding of Long-Term Care ['Fees Working Party'], looking at the costs of care of the elderly.

- The impression of too many committees, too much duplication of function, and at times insufficient acceptance of shared responsibility nonetheless persists. A streamlining of these facets of government is one of the hoped for outcomes of the recently announced internal review.

- There is increasing evidence of 'what works' in population based health policy. The better health information resources developed over the past few years must now be better used to develop and drive 'evidence based' health policy.

- Further extending this to 'evidence based medicine' and putting 'what works' into practice on the wards and in the surgery has been relatively neglected in Guernsey. Implementing best 'evidence based' healthcare must be a focus for increasing investment and commitment in the years ahead.

- 'Quality Counts' - just as there must be a concentration on doing more of those things of proven effectiveness, so it will be increasingly important to demonstrate that there is a matching commitment to the quality of services provided. This is another relatively underdeveloped aspect of healthcare in Guernsey.

- 'Clinical governance' would seem to have particular relevance to achieving this in Guernsey, given the history of how health services and health service delivery have evolved on the island. It is hoped that the development of 'clinical governance' in the local context will help demonstrate to the people of Guernsey the equal and shared commitment to 'quality of service' held by both Board of Health staff, and health professionals in private practice.

References

Secretary of State for Health *'Our Healthier Nation - a Contract for Health'* Consultation Paper HMSO 1998

White Paper *'The New NHS: Modern, Dependable'* London HMSO 1998

Chief Medical Officer *'Interim Report of a Project to strengthen the public health function in England'* Department of Health 1998

Chapter 3

Avoiding the avoidable

'New Epidemics'

In the '*World Health Report' [1997],* the World Health Organisation [WHO] observes:

'The World is in a health transition. Infection as a major cause of suffering and death is giving way to new epidemics of non-communicable disorders, such as cardiolvascular disease, diabetes, and cancer'.

Avoidable ill health in Guernsey will be the special theme of this Chapter.

Tobacco

In 1992, the UK Government White Paper *'The Health of the Nation'* concluded that *'smoking remains the largest single cause of preventable mortality in England'.*

More recently in 1995, the World Health Organisation has proposed a 'cancer priority ladder' which gives internationally agreed priorities for developing effective cancer control. To achieve this, the WHO concludes *'tobacco control is the most urgent need'.*

Against this national and international background, the decision of the States to support the 'tobacco package' brought by the Board of Health [Billet d'Etat XII 1996] must be seen as courageous, but correct. Indeed, the then Chief Executive of Action on Smoking and Health - [ASH], described it at the time as *'the most important precedent in tobacco control in the Western World in recent years':*

Progress in tobacco control since July 1996 will now be summarised.

- **Advertising Ban**

This legislation came into effect in November 1997. Shopkeepers and other retail outlets were given one year to remove fixed display materials, apart from at 'point of sale'.

Tobacco advertising appearing in imported print media should also diminish considerably following the decision to implement the EU Directive banning tobacco advertising and sponsorship in all EU Member States.

- **Tobacco Pack Warnings**

Contact with the tobacco importers is also being maintained. In due course, it is hoped that agreement can be reached on specific Channel Islands health warnings.

- **Raising Legal Age of Purchase 16-18 years**

This was agreed by the States in January 1997. The intent of the legislation was not to criminalise minors attempting to purchase cigarettes, but to help shopkeepers from inadvertently selling tobacco products to children sometimes as young as 12 or 13 years of age.

There is evidence that this has been successful. A 'test purchase' scheme in which volunteers from the 'Smokebusters' Organisation who looked and were well under 13 years of age attempted to purchase cigarettes from a variety of retail outlets in both town and rural parts of the Island took place in 1995, and again in 1997.

There was adequate 'warning publicity' on both occasions. The number of successful 'test purchases' fell from 40% in 1995 to only 12.5% in 1997.

- **Helping addicted smokers quit**

The 2nd Guernsey *'Healthy Lifestyle'* Survey published in 1993 showed that 67% of regular smokers in Guernsey stated they wished to give up.

However, nicotine is notoriously addictive, and it is estimated that 95% of addicted smokers fail on each and every occasion they attempt to stop.

– Nicotine Replacement Therapy

There is good medical evidence, however, that nicotine replacement therapy and 'brief interventions' from health professionals, such as their family practitioner or a trained counsellor can do much to improve success rates. 'Free' nicotine replacement therapy has therefore been available through family practitioners, and community pharmacists during 1997, and from family practitioners, community pharmacists and the Guernsey Quitline in 1998.

– Guernsey Quitline

The Guernsey Quitline is an independent organisation established in October 1997, and run from the Guernsey Chest and Heart Association. Two trained counsellors offer information, formal and informal support, both over the telephone, and in a variety of other locations. An evaluation of their first years impact in being contacted by, and assisting smokers to quit should be available by December 1998.

- ***'Making smoking less attractive, less accessible, and less affordable to young persons'***

To the generation who grew up after the war, smoking was very much an acceptable social norm, and many people became addicted in their early years, and have found it difficult to quit smoking since then.

With the huge increase in knowledge about the adverse effects of tobacco smoking, the major objective of the 'Guernsey smoking package' must be to prevent another generation of young people in Guernsey becoming so addicted.

Specific activities have included the setting up of GASP [Guernsey Adolescent non-Smoking Project]. This includes 'Smokebusters' operating in all Guernsey Primary Schools, and BREATHE established to inform and assist the older age group, in both school and out of school settings. Informal feedback from both organisations suggests that young people as young as 13 years who have been regular smokers have now come forward for assistance to help them stop.

Further details of health promotion activities directed to reducing the burden of smoking related disease and death in Guernsey will be found in the Health Promotion section of this Report.

- **Increase in Tobacco Excise**

Because of the relatively low 'price elasticity' of tobacco [estimated from -0.3 to -0.6], increased prices alone will only persuade a minority of smokers to quit. However, in conjunction with the range of other supportive measures detailed above, success rates are likely to be much higher.

The Board of Health in collaboration with the Department of Medical Statistics at the University of Southampton will be conducting the 3rd Guernsey *'Healthy Lifestyle'* Survey in October 1998. Amongst much other useful health information being collected, it should indicate how successful the progressive rise in prices has been in dissuading people in different age brackets from continuing to smoke.

The interim results are expected in January 1999. Informal feedback through 'Quitline' Counsellors and others is that for the majority of adults who state they would like to quit smoking, the knowledge of progressive and inevitable price rises in the years ahead is a powerful incentive to stop.

Smoking, Alcohol and Health

It can be truly said there is 'no such thing as a good cigarette'. Even one cigarette can be demonstrated to treble or quadruple blood carbon monoxide levels, raise blood pressure, reduce lung function, etc. A regular 20 or 25 cigarettes a day is certain to do very much more damage to health. It is small wonder that the majority of adult smokers wish to reduce smoking. It is unfortunate that the addictive nature of nicotine makes it extremely difficult for them to do so.

In contrast, alcohol in moderation almost certainly does no harm, and amongst the middle-aged, there is now persuasive medical evidence that it may be beneficial to health.

It has also been estimated that 82% of regular drinkers suffer no serious harm through their drinking, and indeed very few regular drinkers express the wish to reduce their drinking levels.

Unfortunately, alcohol in excess can cause problems, which may be both short-term, eg public drunkenness and vandalism, drink driving, domestic abuse, gastritis, gout, poor work performance, work absenteeism, etc. It may also cause longer term problems, such as work difficulties, financial difficulties, job loss, high blood pressure, cirrhosis of the liver, depression, attempted suicide, and successful suicide.

In one year in England and Wales [1992], it has been estimated that the direct costs of alcohol misuse including sickness absence, cost to the NHS, criminal justice proceedings, etc, cost a massive £2,703.45m. The uncosted elements [such as reduced productivity, cost of social and family disharmony, etc] would have added much more to this.

Does Guernsey as a community have a 'alcohol problem'?

The French social demographer, Solly Ledermann, produced much evidence in the post war years that the level of demonstrable harm attributable to alcohol was directly proportional to average per capita levels of consumption, and that this could change over time. For example, when average alcohol consumption decreased, [as during an economic slump], there was a corresponding fall in the social and health costs attributable to alcohol. On this basis, Guernsey as a community might be predicted to have a significant 'alcohol problem'.

After discounting for visitor consumption, residual per capita alcohol consumption in Guernsey is high by Western European standards. Average per capita consumption at 11.14 litres pure alcohol equivalent [PAE] per year [1990] is well above the UK, Netherlands and Italy, somewhat above Germany and Spain, and only a little below France.

Similarly, deaths certified by doctors as due to liver cirrhosis or otherwise being alcohol related at 10.6 per 100,000 population per year [average 1989-93] are considerably higher than in England [6.0 per 100,000 population per year in 1991]. Cirrhosis of the liver is also believed to be a good proxy for other alcohol related health damage.

In 1994, informants from other States Committees and voluntary bodies dealing with social problems in the community also rated alcohol abuse as the most significant health problem facing Guernsey. It was accordingly selected to be included amongst the six top health priorities for the Health Promotion Unit to address in the quinquenium 1995- 1999.

Against this view, admissions to the Castel Hospital directly related to alcohol are relatively low [44 persons in 1995, 26 persons in 1996], although there were significant numbers of re-admissions in both years.

What needs to be done?

At the 1995 States Budget Debate, the States Board of Health were directed *'to investigate the effect that alcohol and tobacco advertising has on encouraging people, particularly young people, to smoke tobacco and drink alcohol, which investigation shall include consideration of whether an increase in duty on alcohol and tobacco should be recommended annually in the future budgets'.*

The results of the 'tobacco debate' are well known, and the implementation of Guernsey's 'tobacco package' has been summarised above. The Board of Health considered the situation with regard to alcohol was far more complex, and the Director of Public Health therefore undertook to thoroughly research the subject, before advising the Board on what measures were likely to be effective in the local context.

The results of this research, including preliminary results of the Guernsey *'Alcohol and Young Adults'* Survey, were published as a Special Supplement to the 98th Annual MoH Report in 1997.

Full results of the Survey have since been presented at two National Conferences, and valuable input obtained from a range of experts and workers in the alcohol field.

The Board of Health has also organised a half day workshop in which both States Members, representatives of other States Committees, and workers in the drugs and alcohol field in Guernsey were invited. Action on alcohol does not appear to be regarded as a high priority by those who attended.

- **Opportunities for change**

From the research published in the Special Supplement, the findings of the Guernsey *'Alcohol and Young Adults'* Survey, and feedback from experts in the field, the following conclusions can be cautiously drawn.

- Even after correcting for visitor consumption, Guernsey's per capita alcohol consumption is undoubtedly high by Western European standards.

- A minority of Guernsey residents are undoubtedly suffering severe health consequences, and even premature mortality attributable to their alcohol consumption.

- There is inadequate evidence to measure the adverse impact of alcohol on other aspects of island life, such as inefficient work performance, alcohol related absenteeism, social damage and divorce, etc, but this may be considerable.

- Evidence published in the Special Supplement to the 98th Annual MoH Report, shows that there are essentially two separate [both not exclusive] approaches to alcohol control. These may be summarised:

– **'High risk' strategy;** - essentially targeting resources at reducing 'high risk' drinking, and attempting to 'pick up the pieces' after alcohol related harm.

– **The 'population approach';** - here there is an attempt through such mechanisms as raising price, restricting availability, reducing demand through bans on advertising, etc to reduce overall consumption of alcohol in the community .

Under the so called 'prevention paradox' [more fully explained in the 98th Annual Report Supplement], there are greater health and social benefits in moving from a 'wet culture' [where use of alcohol is high and alcohol related problems are common], towards a 'dry society' [where overall consumption is lower, and abuse of alcohol is less socially acceptable], than merely attempting to deal with the problems of alcohol abuse in isolation.

- Whether a particular community must be seen as 'wet' or relatively 'dry' is highly dependent on cultural factors, and particularly the acceptability and acceptance of alcohol abuse.

- As explained in the '98th Annual MoH Report, levels and patterns of life-time alcohol use are set in early adulthood. The results of the Guernsey *'Alcohol and Young Adults'* Survey suggests that alcohol consumption has a central place in the personal and social lives of many young people aged 18-24 years in Guernsey. It also accounts for a large proportion of their discretionary spending.

- The majority of young people interviewed stated that alcohol advertising had little influence on their choice of drink, and that a rise in the price of 20% would not influence their choice of drink.

The results of these investigations, and comments received will form the basis of a Report to the Board of Health, who will in turn report back to the States on what measures [if any] are desirable to address the demonstrated problem of alcohol abuse in our community.

It must be said though, that any measures proposed by the Board of Health are unlikely to achieve success unless there is widespread support both in the States, and by the community more generally.

At present, though, there appears to be little public demand for the measures necessary to address these issues, and only limited political support.

Action on Drug Abuse

The growing use of drugs, and the personal, social and societal harm which may result from their abuse is now recognised world-wide. In Europe, tackling drug dependency is one of five selected fields for EU - wide programmes.

Following the publication of *'Tackling Drugs Together'* in Britain in 1995, local 'Drug Action Teams' have brought together top level personnel from the various agencies involved to successfully co-ordinate local action against drugs. Building on this framework, the new government has appointed Keith Hellawell [previously a high ranking and outspoken police officer], as the first UK anti drugs co-ordinator ['drugs czar']. After some months of consultation, he has in turn produced a further strategy document *'Tackling drugs to build a better Britain'.*

In our sister island, Jersey, *'The misuse of drugs- a combined a approach '* [1995] was followed by *'Working together against drugs - A strategy and implementation plan'* in 1996. A Crime and Drugs unit has now been established, with its own budget and staff to co-ordinate the action deemed necessary. A key feature of the Jersey approach is the separation of policy [developed by the President's Policy Group], strategy [the responsibility of a Chief Officers' Strategy Group] and co-ordination of operational issues [delegated to senior officers].

- **Developing a Guernsey Drugs Strategy**

Against this background, and on the advice of its Dependency Sub-Committee, the Board of Health invited representatives of the Jersey Drugs Strategy Group to address a meeting of members and officers of key States Committees in Guernsey in January 1997.

An outcome of this was a meeting of Presidents, who have now asked the Chief Officers of their respective States Committees to review current measures to combat the drug problem, and advise on any new approaches or changes, which may be desirable.

- ***'What good are we trying to achieve.... ?'***

A sound drugs strategy needs to be underpinned by a solid philosophical base. There needs to be a general agreement on *'what good are we trying to achieve?',* and conversely *'what harm are we trying to prevent?'.*

From the increasing amount of published material exploring the reasons and results of increasing drug use world-wide, certain key themes emerge.

These include:

– **Principle of harm minimisation;** Drug use may be undesirable, it may sometimes be deadly, but the evidence is that the demand for, and use of drugs on a world-wide basis has not yet plateaued.

  If we accept that the demand and use of drugs will probably continue to increase in the short-term, despite our best efforts at prevention and containment, then it becomes imperative to ask: *'what further steps can we as a community take which will lead to better harm minimisation? - that is to minimise harm to the individual? - and also harm to the wider community?'*

- **Use of evidence;** *'Tackling drugs to build a better Britain'* estimates that total government expenditure for 1997/98 for all aspects of drug control in the UK was £1.4 billion. Of this, 62% was spent on enforcement related work, 13% on treatment, 12% on prevention and education, and 13% on international supply reduction.

  It is suggested that current approaches may not represent the best 'value for money', and may indeed not be working. There is a need to examine the evidence as to what does work, and implement newer approaches, as well as, or instead of less effective existing approaches.

- **'Treatment works';** there is in fact increasing evidence that appropriate treatment is not only more effective, but is also considerably cheaper than more traditional approaches. The above Report concludes *'£3 is saved for every £1 spent on treatment,* and *this saving occurs across a range of treatment modalities'*. In contrast, 'enforcement strategies are said to have a net cost'.

Getting the right mix and balance between education and prevention, supply reduction and enforcement, and treatment and rehabilitation for Guernsey now and in the future will not be easy.

As Keith Hallawell has commented *'The success of a drugs strategy should not be judged by the number of persons who have or have not tried drugs, but by the amount of permanent damage that has been prevented'*.

It is hoped that building on the principle of *'harm minimisation'*, and using the increasingly convincing evidence of *'what works'*, that the Chief Officers' Drugs Strategy Group will be able to make recommendations which ensure that Guernsey gets more and better 'value for money' from the resources invested in drug control measures.

Cancer in Guernsey

When we talk of 'cancer', we are really talking about over 100 separate disease entities. However, these all share certain common characteristics in terms of cause, which depends on the mix and balance between genetic factors, exposure to environmental agents, and the individuals own immunological defences and responses.

Similarly, there are certain common approaches to prevention and treatment. These include avoidance of known environmental risk factors, early detection in those at risk, 'evidence based' treatments to achieve best outcomes, effective rehabilitation, and quality palliative care for those in whom the disease is progressive despite treatment.

Cancer is a proportionately large cause of morbidity and mortality in Guernsey. 28.7% of all deaths in Guernsey [1983-1993] were due to various cancers, compared with only 25.1% in England and Wales [1991].

However, deaths from circulatory diseases were relatively less in Guernsey [40.7%] compared with 46.1% of all deaths in England and Wales during these years.

The relatively larger proportion of cancer deaths in Guernsey is probably due to a combination of factors, including differences in exposure to environmental risk factors [eg tobacco smoke], and the greater expectation of life in Guernsey described in Chapter 8. 70% of all cancers occur in people more 60 years old.

- **Preventable Cancers**

It has been estimated that 75% of all cancer at present can be better prevented, detected or treated by better application of our existing knowledge. Amongst those cancers most amenable to prevention or early detection are cancer of the lung [through better tobacco control], and cancers of the breast and cervix [through more effective population screening]. With regard to breast cancer, screening using mammography, and proficient investigation of symptomatic breast disease offer the best opportunities for reducing mortality from this cause.

- **Breast Screening**

2,806 women were invited for breast screening during 1997, of whom 2,452 [88%] attended. The invite/recall system was originally set up so that the breast screening unit do not know who has been invited, and it is therefore not possible to follow-up non responders to the initial invitation.

Of those who have attended for screening, 125 [5%] were invited for further assessment, which is well within UKNHSBSP [United Kingdom National Health Service Breast Screening Programme] quality standards for numbers of women recalled.

From those 125 women assessed:

- 13 cancers were detected, giving a detection rate of 10%, which is in line with the ISK BSP.
- 11 of the women elected to have surgery in Guernsey.
- 2 chose to go to the UK for private treatment.

All other women assessed were found to have either benign disease or no significant abnormality and have been returned to routine screening.

Symptomatic Breast Disease

The management of symptomatic breast disease has also changed during 1997. All new referrals are now seen by the breast surgeon in a specific 'new patient' clinic, which is held on a Tuesday in the breast screening unit. All referrals are seen within five working days of receipt of referral from the general practitioner.

Those women requiring breast imaging return on the following day for imaging and biopsy if required.

All cases seen in the Tuesday clinic are reviewed by the breast care team on Friday, and all women return on Friday for results and future management planning.

This has provided streamlining of patient management, allows input from the whole breast care team into each woman's management, and ensures no one is lost to follow up. 26 breast cancers were detected in symptomatic women during 1997, many of whom fall outside the age range for breast screening.

A '5 year' review of the Guernsey Breast Screening Programme, and its impact on local cancer mortality rates will be included as part of the 1998/99 Annual MoH Report.

Dr Louise Gaunt
Consultant Radiologist

Cervical Cytology

The cervical cytology screening service in Guernsey was contracted out to the CPA accredited BUPA laboratory in Bristol in October 1996.

This followed a review of the service in the light of the new NHS Cervical Screening Programme (NHSCSP) guidelines which requires that a laboratory undertake a minimum of 15,000 slides annually to maintain acceptable quality control standards, and provide results within a maximum of 28 days. These basic standards could not be met in Guernsey due to the small workload and the civil service manpower cap, and it was therefore a logical decision to outsource the work to tender.

The initial year of the new screening arrangements have proved successful from both the view of the Island's general practitioners and their patients with rapid turn around of results and excellent administrative support. The contract was re-tendered in October 1997, and BUPA again provided the 'best buy' and will continue to look after Guernsey for the next 5 years. The BUPA laboratory meets all the accreditation standards of the NHSCSP.

In 1997 a total of 4,806 smears were taken for screening of which 155 [3.2%] showed abnormalities and in 89 [1.9%] these abnormalities were of the moderate to severe form of pre-cancerous change. 179 [3.7%] smears had to be repeated because too few cells were present for evaluation on the smear. These percentages are well within the expected ranges for abnormalities as found in the UK national guidelines as is the number of unsatisfactory smears.

Four invasive cancers were detected in women in Guernsey during 1997, one as a result of screening, and three in women who presented symptomatically but who had not had a cervical smear in the previous 10 years at the minimum.

This highlights the need to continue to publicise the availability and value of cervical screening for all women in the target age group of 20 to 60 years.

Finally it must be emphasised that this is a 'screening' programme which has an effectiveness of 93-95%) in picking up cervical pre-cancerous change. It was never intended to be nor ever can be a 100% effective as the media try to portray, and there will always be a small number of false positives and false negatives.

A useful source of information is the American Society of Clinical Pathologists on the Internet at *http://www.acsp.org/eos/papsmear/paplook.html.*

Dr John Buchanan
Consultant Histopathologist

- **Cancer Units and Cancer Centres**

ln April 1995, the Expert Advisory Group set up by the Chief Medical Officers of England and Wales produced a Report *'A policy framework for commissioning cancer services* . This pointed out that people with similar type and stage of cancer showed considerable differences in length of survival and mortality rates, depending on where they lived, and where they received their cancer treatment.

Generally, centres treating low numbers of particular cancers had much worse outcomes than larger centres dealing with higher numbers. Moreover, the Report also noted that there was considerable variation in the type of treatment given, and the 'best evidence' was not always used when choosing the most appropriate treatment.

This lead the Group to propose a 'hub and spoke' model with the more common cancers being treated at cancer units [situated around the periphery], whilst more serious/less common cancers were treated at specialist 'cancer centres' [at the hub].

- **Regional Implementation**

The Report proposed a national strategy, with local flexibility to address regional differences. As it moved into its implementation phase, it naturally stimulated debate on 'what should be done'?, where? and, by whom?'

The Regional Cancer Organisation for the South and West proposed that this should be examined on a 'cancer by cancer' basis, to define:

- Where treatment could be optimally given.
- Desirable number of procedures to be performed annually.
- Ancillary and support services needed.
- Contractual relationships.

Relevance for Guernsey

Against these far reaching. developments in the structure, provision, and underlying philosophy of cancer services in England, it was felt appropriate to review cancer services at all levels in Guernsey.

A **Cancer Strategy Working Group** consisting of local and visiting clinicians, and others involved in the provision of cancer services first met in June 1997.

It has adopted as its terms of reference:

'To produce a strategy, implementation of which will result in effective preventative measures being taken, and Guernsey residents receiving the best possible treatment and care compatible with living on a island, all within the constraints of resource availability'.

The Guernsey Strategy Group hopes to produce an interim report by early 1999.

Cancer treatment 'far from home'

In the context of a regional strategy, most patients in the UK no doubt appreciate the advantages of travelling to a larger regional centre in the expectation of a better clinical outcome, in comparison with being treated closer to home.

Deciding on the most appropriate place for treatment becomes more difficult in an island context. If all cancer treatment were to be referred 'off island', costs would probably be unsupportable, and local practitioners would become progressively more deskilled, and eventually unable to offer even quality emergency care.

Further considerations must include 'patient perception' and 'patient satisfaction'. The diagnosis and treatment of cancer is always emotionally traumatic, and receiving this 'far from home', and away from family and social support networks might be predicted to be even more stressful.

Surprisingly, there is very little published in the medical literature about the psychological and social effects of receiving major treatment away from family and social support. Accordingly, and in order to better advise the Board of Health on the appropriate mix of cancer services on and off island, the Cancer Strategy Group has commissioned the Health Research Unit at the University of Southampton to undertake a research project examining 'cancer treatment far from home'.

The project will commence in early autumn 1998, and use an interviewer administered structured questionnaire to compare the experience of 50 consecutive Guernsey patients referred for treatment at the Wessex Cancer Centre, [who will be spending Several weeks away from home], with the experiences of a further 50 patients matched for age, sex and type of cancer, but living within the Southampton catchment area, and generally able to return to their homes at night.

The project should be completed by late spring 1999, and should benefit not only local patients needing to seek cancer treatment 'far from home', but should also prove useful when planning services for people from other island and remote communities.

Sexual Health

Sexual feelings, sexual emotions, and sexual activity are a normal, and for most people an important aspect of their overall being and well-being.

However, as in many other human activities, better health can lead to greater enjoyment.

Until the recent past, sex, sexual activity and sexual health were rarely addressed within the overall health concept. However, the advent of the HIV virus, and the still evolving AIDS epidemic have forced health planners and public health practitioners to look afresh at the determinants of sexual health. The promotion and protection of sexual health is now recognised as a legitimate field of public health activity.

What is Sexual Health?'

Sexual health may be broadly defined as *'the potential for enjoying the sexual activities of one's choice, without causing or suffering physical, social or mental harm'.*

As with much other public health endeavour, the promotion and protection of sexual health requires the support of, and contributions from many other sectors.

A comprehensive approach to promoting and protecting sexual health must include:

- Ensuring that young people receive effective education about sex and relationships as part of their entitlement to personal and social development.
- Encouraging openness, knowledge and understanding about sex and sexual health amongst young people, adults and the wider community.
- Ensuring that all sexually active people have access to a range of effective health advice and services, including contraception, sexually transmitted diseases - diagnosis and treatment, fertility advice, and termination of pregnancy in accordance with the law.
- Educating and enabling people to use these services.
- Facilitating healthier sexual behaviour choices.
- Surveillance and research to help support the above.

Expected outcomes from a more comprehensive approach to sexual health must include:

- Reducing the incidence of unintended and unwanted pregnancies.
- Reducing the spread of Chlamydia, and other sexually transmissible diseases.
- Reducing the incidence of HIV infection, and ensuring appropriate treatment is available for those already infected.
- Enabling women to make informed choices regarding the continuation of unwanted pregnancies.

How well Guernsey is doing against these parameters of a comprehensive approach to sexual health may be judged from the reports contained in Chapter 6 of this Report, which for the first time contains details of Family Planning Clinic attendances, and abortions lawfully performed under Guernsey's 1997 Abortion Law.

- **Guernsey Sexual Health Forum**

The Green Paper *'Our Healthier Nation'* suggests that *'connected problems require joined up solutions',* and nowhere is this more true than in the field of sexual health.

In the 98th Annual MoH Report [1996/97] it was noted:

'Sexual Health ix obviously an area of increasing importance, and one where there are obvious opportunities for a more co-ordinated and integrated approach between the various agencies involved'.

This hope has now been realised, and a Guernsey 'Sexual Health Forum' has been meeting since the beginning of 1998. The Sexual Health Forum brings together on a informal basis representatives of the Sexual Health Clinic, Health Promotion Unit, Complementary Health Educators [States Education Council], Nurse Education, Children Board, Family Practitioners, Specialist Gynaecologists, the Child and Adolescent Mental Health Service, Learning Disabilities, and the Guernsey Family Planning Clinic.

With rapid developments occurring in several fields of sexual health, the Forum has proved to be invaluable for communicating experience, and planning joint approaches. It is to be hoped that present informal contact will lead to better co-ordinated working amongst the various agencies involved in the field of sexual health in Guernsey.

Chapter 4

Environmental Health Department

• Introduction

Changes to the implementation of environmental health in Guernsey were signalled in 1997.

In February, the States of Deliberation approved significant amendments to existing public health legislation and also the introduction of The Control of Environmental Pollution Law.

It was agreed that statutory nuisances be redefined and powers to seek abatement be strengthened.

A legislative framework to control pollution in respect of waste, seawater, noise and air was agreed, permitting the introduction of separate Ordinances for each of these aspects.

In the UK, the Pennington Report on the circumstances leading to the 1996 outbreak of infection with E. Coli 0157 in Central Scotland was published in April. The report recommended changes in the approach to hygiene with regard to meat production and sale.

Attention was called for in respect of farms and livestock, slaughterhouses, meat production premises and butchers' shops and points of consumption. A greater emphasis was placed on hygiene awareness and hygiene hazard analysis.

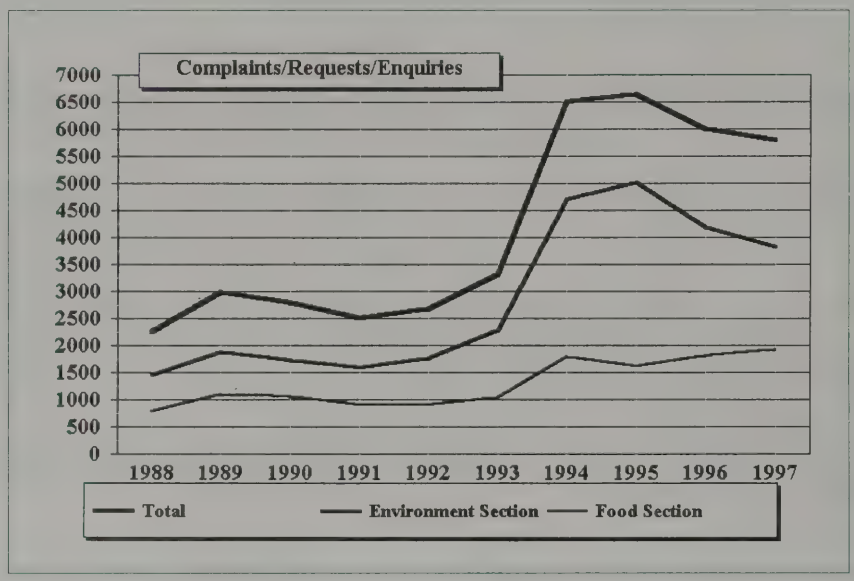
Officers from the department and the States Committee for Agriculture formed a liaison committee, under the chairmanship of the Director of Public Health to ensure that Professor Pennington's recommendations were implemented in Guernsey.

As the Board of Health's role as Waste Regulation Authority continued to progress, the department's technical assistant was appointed to the post of Trainee Waste Regulation Officer on the 1st June and he began studying for a Masters Degree in Waste Management. The Board's consultants, ERM, continued to advise the Board on the development of a Waste Management Licence for Mont Cuet Landfill Site.

Consultative links were also established with the Waste Regulation Division of the UK Environment Agency.

Complaints/Requests for Advice/Enquiries

A total of 5762 complaints/requests for advice/enquiries were received during the year: This figure represents a reduction of approximately 5% compared with the previous year. The details are shown in the tables and the graph.



Food Safety and Infection Control

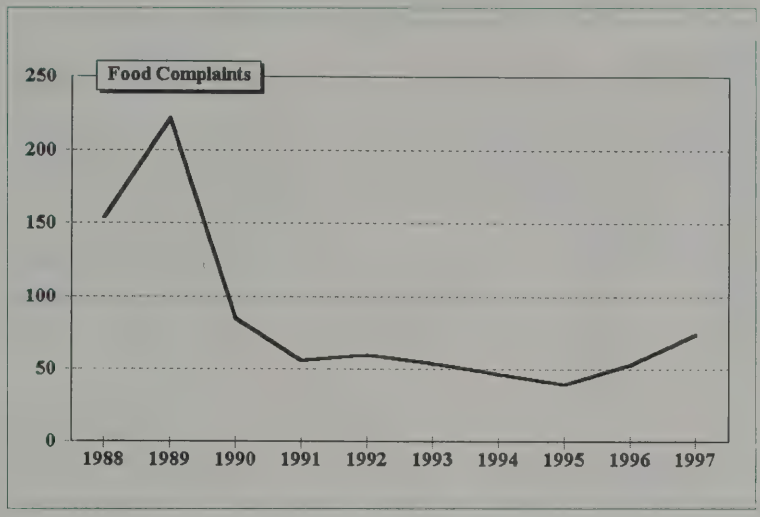
Whilst there was a reduction in the overall number of complaints, etc., the Food Safety section dealt with a total 1930 complaints, etc. - an increase of approximately 6½% over the previous year. In the main this increase can be attributed to advice sought regarding the introduction of new food legislation.

Food Safety and Infection Control

Food Condition	212
Food Poisoning	396
Food Safety	751
Food Surrender & Advice	66
Miscellaneous	505
Total	1930

Food Complaints

74 complaints were made to the department during the year. Of these 29 were either unsubstantiated or the source of the problem occurred (accidentally) in the complainant's home. The remainder related to food not being the nature, substance or quality demanded by the purchaser. None were of such seriousness as to warrant formal action.



Food Surrender

A total of 28 certificates were issued during the year: an indication that the Board's policy of charging for the issue of certificates continues to have the desired effect of releasing officer time.

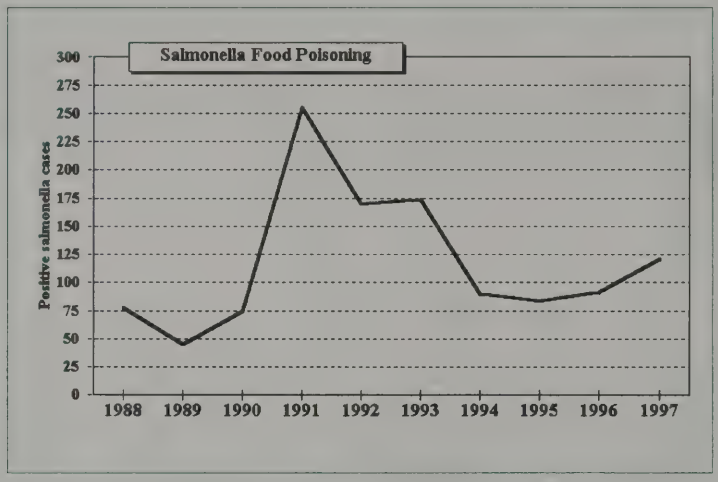
Education

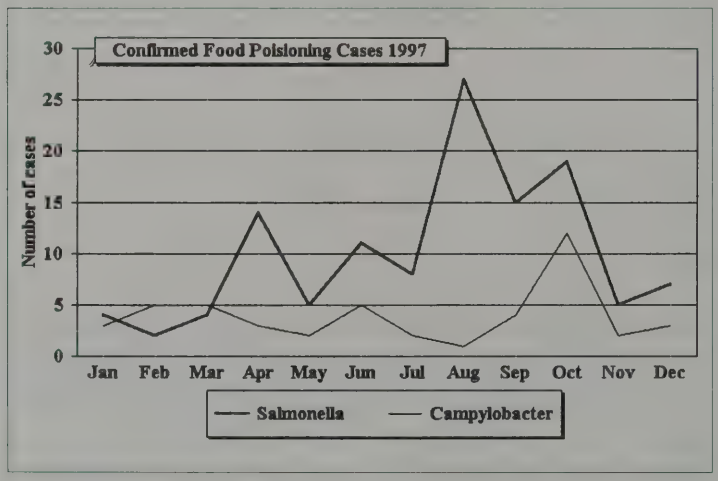
The Environmental Health Officers continued to promote the Chartered Institute of Environmental Health's Basic Food Hygiene Certificate course. A total of 34 candidates attended a total of 5 courses run by the department.

Food Poisoning

The Department received notification of 121 confirmed cases of Salmonella food poisoning. 91 of these were of the type usually associated with chicken or eggs. The majority were individual cases or family outbreaks. One incident, involving 8 positive cases, was investigated and although the infection was likely to have been acquired from a common source, there was no bacteriological proof that the infection originated from a particular local restaurant. There were, in addition, 47 confirmed cases of Campylobacter.

It has to be stressed, yet again, that dishes made with uncooked fresh eggs pose the risk of salmonella food poisoning and previous advice given to all hotels ad restaurants is repeated: *"to avoid similar problems, use pasteurised liquid egg for catering purposes".*

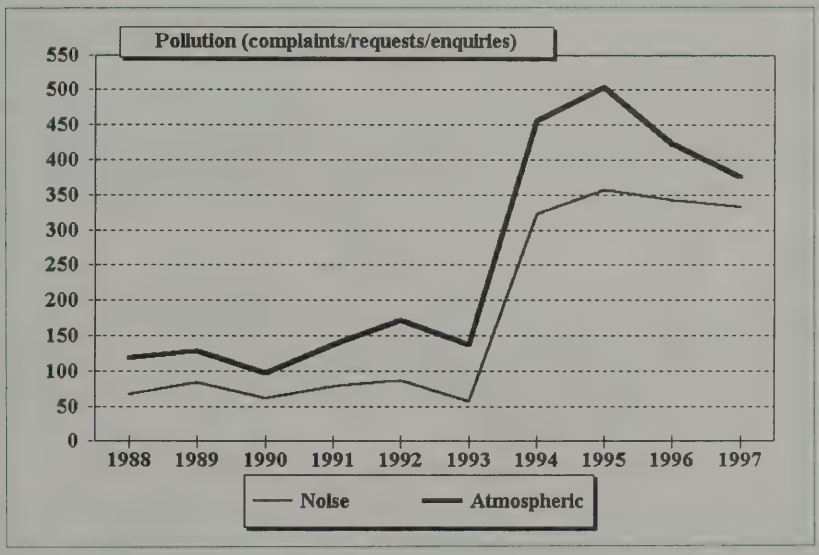




Control of the Physical Environment

A total of 3833 complaints/requests/enquiries were dealt with during the year.

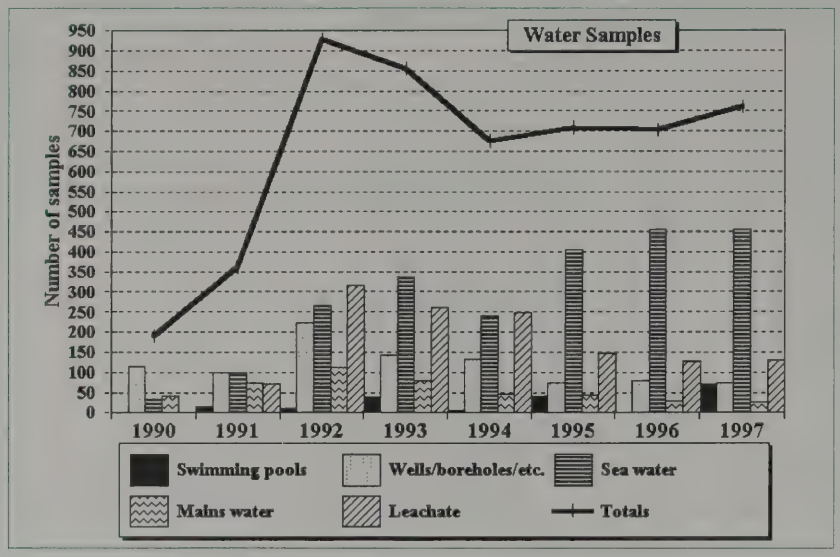
Environmental Control	
Housing	418
Pollution - Atmospheric	376
Pollution - Land/Water	299
Pollution - Noise	333
Rats/Mice/Pests	1052
Water Sampling	318
Miscellaneous	1037
Total	3833



Water Samples

The following samples were taken during the year for bacteriological and/or chemical sampling.

Water Samples	
Swimming pools	72
Wells/Boreholes	75
Sea Water	456
Mains Water	27
Leachate	129
Other Water Sources	2
Totals	761



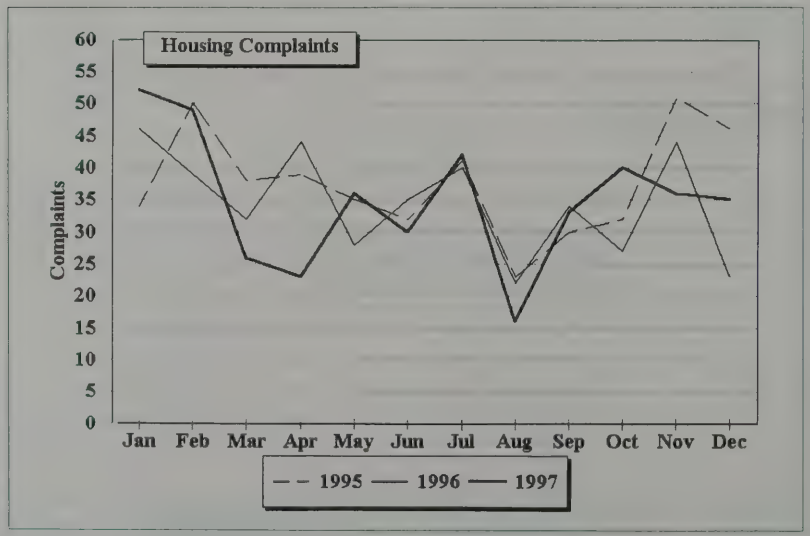
Rodent and Pest Control

A total of 539 complaints or requests for assistance were dealt with by Rodent Control staff and a total of 822 treatments were carried out. Staff also carried out 185 disinfestations .

The Department continued with its programme of the systematic treatment of bays headlands and staff carried out 554 treatments during the year.

Housing

409 complaints of unsatisfactory conditions were received during the year. Complaints were mainly concerned with unsatisfactory living conditions, overcrowding dampness ad defective drainage. The accompanying graph shows the frequency of complaints.



• Air Quality Monitoring

The department continues to monitor nitrogen dioxide and sulphur dioxide levels. Nine sites measuring nitrogen dioxide were in operation for the whole of 1996 whilst the one site monitoring sulphur dioxide operated near the Vale Power Station.

Measured levels of sulphur dioxide remain very low, indicating "Very Good" air quality, based on the United Kingdom's Department of the Environment's Air quality Banding. The levels are now at or below the detection limits of the measurement equipment.

Nitrogen dioxide levels were similar to 1996 but continued the downward trend noted last year. Fountain Street again reached the highest levels with a monthly average of 18.89 ppb (parts per billion) with a peak of 23.90 ppb (in July). The compares to an average of 19.51 ppb in 1996 and 20.28 ppb in 1995. Peak levels for the previous two years were 26.00 ppb (September 1996) and 26.18 ppb (August 1995). Rural average levels were under 10 ppb. "Very Good" air quality is indicated by levels below 50 ppb, based on the Air Quality Bandings.

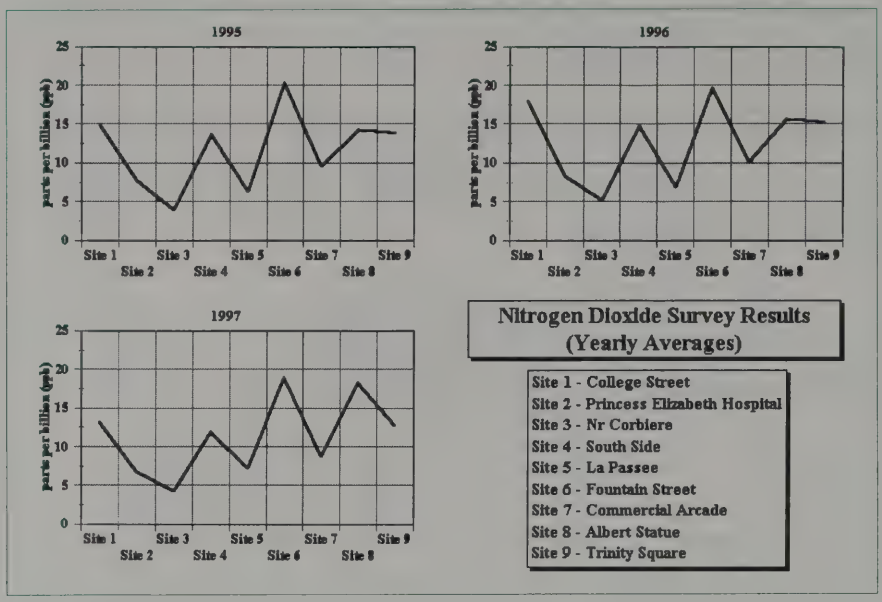
The South East Institute of Public Health reported to the Environmental Health Department during 1997 concerning the siting of real time air pollution monitoring equipment. Three sites have been recommended; including the rural site measuring ozone, a busy roadside site in St Peter Port measuring oxides of nitrogen and carbon monoxide and an urban background site, again in St Peter Port, measuring oxides of nitrogen, sulphur dioxide and particulate matter. Agreement to use at least one of the sites was still awaited at the end of 1997 and it is envisaged that the equipment will be purchased and commissioned during 1998.

Nitrogen Dioxide Survey Results (Yearly Averages)

Site	1992	1993	1994	1995	1996	1997
College Street	17.42	15.36	14.03	14.91	17.85	13.06
Princess Elizabeth Hospital	5.74	9.86	6.83	7.69	8.23	6.75
Nr Corbiere	3.32	5.52	3.62	3.86	5.19	4.30
South Side	8.79	14.80	12.15	13.58	14.78	11.91
La Passee	6.57	7.16	6.37	6.33	6.91	7.23
Fountain Street				20.28	19.51	18.89
Commercial Arcade				9.47	10.11	8.75
Albert Statue				14.16	15.58	18.15
Trinity Square				13.82	15.25	12.73

All results in ppb (parts per billion)

1992 averages for first five sites are for November - December only
1995 averages for last four sites are for August - December only


1995
1996
1997
parts per billion (ppb)
0
5
10
15
20
25
Site 1
Site 2
Site 3
Site 4
Site 5
Site 6
Site 7
Site 8
Site 9
Nitrogen Dioxide Survey Results
(Yearly Averages)
Site 1 - College Street
Site 2 - Princess Elizabeth Hospital
Site 3 - Nr Corbiere
Site 4 - South Side
Site 5 - La Passee
Site 6 - Fountain Street
Site 7 - Commercial Arcade
Site 8 - Albert Statue
Site 9 - Trinity Square

Chapter 5

Health Promotion Unit

• Introduction

1998 saw the celebration of the Unit's 10th birthday with an Open Day and various displays. This provided the opportunity to review some of its past achievements and also promote its services to yet more clients. The past ten years have seen the growth and development of Health Promotion as a basis for healthier lifestyles into the next millennium. Shortly after the birthday celebrations the Unit bade farewell to Mrs Diana Reade, secretary, who had been with the Unit almost since its inception. However Mrs Pam Marsh was welcomed in her place, and she is already well settled into the post.

• Accident Prevention

The Health Promotion Officer continued to chair the Child Accident Prevention Group. The group has representatives from many different organisations involved in the prevention of injuries to children and the past 12 months have seen a number of activities. These included a schools art competition to design a new logo for the group, a short campaign on winter safety and 4 members attended a conference organised by the Jersey Child Accident Prevention Group. The Health Promotion Officer went to a conference in the United Kingdom which was attended by many different organisations involved in the setting up of accident prevention schemes for children. It was very gratifying to discover that the Guernsey Child Accident Prevention Group's own scheme, the "Safety Calling Challenge", utilised many of the aspects highlighted as good practice at the conference. This year the Challenge was attended by over 400 Year 6 primary school children and proved to be extremely successful. Discussions are now underway to see if the scheme can be repeated next year. The group, through the Health Promotion Unit, has also distributed a beach safety leaflet to the majority of the islands primary and some secondary school children and worked with Guernsey Telecoms to produce a phone card with a home safety message.

• Alcohol

"Too much to drink'? Think" was taken as the campaign theme during December 1997. This linked with the United Kingdom scheme and highlighted the issue of problems associated with excess drinking. The programme included working with the local bus companies so that every bus carried a poster on the campaign theme and alcohol leaflets were given to clients who attended the Accident and Emergency Ward or Police Station as a result of excess alcohol. The message of sensible drinking was also highlighted at various displays around the Island. The Health Promotion Officer continued to attend Drug Concern meetings and led several drug education sessions for teachers. Future plans include involvement in the European Drug Prevention Week in November.

• Cancer

The workplace was chosen as the target group for cancer prevention during the last 12 months. The Assistant Health Promotion Officer organised a seminar on this topic at which 27 different businesses were represented and another 13 requested further information and to be placed on the Units' mailing lists. As a result of the seminar the Assistant Health Promotion Officer then went on to deliver more detailed workshops for 4 of the workplaces.

The prevention of skin cancer was a priority area and a sun awareness campaign was organised by the Assistant Health Promotion Officer which included a workshop for professionals and displays on sun in the garden, on the beach and the dangers to children. A workshop on this topic was conducted for childminders and resources were distributed to a wide variety of locations.

• Coronary Heart Disease

10 different Look After Yourself courses were run during the past year including several for cardiac rehabilitation and weight management groups and the Assistant Health Promotion Officer led a 2 day course for new cardiac rehabilitation tutors. This course continued to receive referrals and support from medical staff both locally and in the UK and the Assistant Health Promotion Officer was involved in arranging the purchase of new exercise equipment for the course, funded through the Hash House Harriers.

The Health Promotion Officer worked as one of three trainers to lead an 80 hour training course in Jersey for new Look After Yourself tutors. Seven Guernsey tutors completed the course and five have run their first sessions. They are now all in the process of gathering evidence for their NVQ qualification: Training and Development Level 3 in the context of Health Education. This has involved a tremendous amount of work but will result in tutors who are qualified to lead sessions in all aspects of health education, not just LAY. It has also meant that both the Health Promotion Officer and the Assistant Health Promotion Officer have had to undertake their NVQ Assessors award, again involving large amounts of time and effort, but this has been of considerable benefit to their personal development. Sadly it has now been decided by the Health Education Authority in England that the Look After Yourself Programme must be wound down by June 1999. A new initiative should be in place by that time and the Unit is awaiting details to see if it will be suitable for Guernsey.

Other activities to promote the prevention of coronary heart disease included workshops on healthy eating for several workplaces and a series of sessions on all aspects of healthy living for the Electricity Board. The Active for Life Campaign continued with the provision of a number of free 'taster' exercise sessions. This campaign is ongoing and later in the year will concentrate on encouraging young women to become more active.

- **Family Health**

Following a request for support, the Health Promotion Officer worked with representatives from the Islands charities for hearing impairment to arrange their successful Hearing, Awareness Week. Breastfeeding Week was again promoted taking the theme "Free fast food for babies" The increasing problems caused by headlice in the Island has meant that future plans will include organising a "Hunt the headlice Week" and supporting the work of health visitors and school nurses in this area and a campaign for Meningitis Awareness Week.

- **Mental Health**

Mental health promotion is a growing area throughout the United Kingdom and locally stress management was seen as an important issue. The Assistant Health Promotion Officer led a number of sessions of stress management and relaxation for 6 different businesses. The Health Promotion Officer also worked with the Teachers Stress Working Group looking at the issues of stress in education and led several workshops for school staff and a number of workplaces. The Resources Officer also increased the number of resources in this area as demand continued to grow.

- **Resources**

The Resources library went from strength to strength with a total of 2,700 items in stock. These include books, teaching packs, videos, models and equipment such as display boards, flip charts and overhead projectors. During the period June 1997 to June 1998, over 46000 leaflets were given out and over 1200 items were loaned out to visitors from 24 different client groups. **The Resources Officer now** has access to a comprehensive computer clip art package and scanner enabling the Unit to produce more professional looking displays and handouts and the first two issues of the Units Newsletter were published and distributed to over 450 contacts. A development has been gaining access to the Internet as well as the installation of a CD Rom as a number of new resources are now available in this medium. It is hoped to have the Units own website in the autumn.

- **Sexual Health**

A group of student nurses completed a survey organised by the Health Promotion Unit on the availability of condoms through vending machines. The results led to talks with the local distributor and the placement of several new machines. The prevention of HIV and AIDS was the topic of a training sessions for teachers and the Health Promotion Officer took part in the NEC training Day on HIV. She also attended meetings of the HIV working party and the recently formed Sexual Health Forum and continued to work with the Family Planning Clinic and the Education Department's Complimentary Health Educators. Leaflets and posters were distributed throughout the Island for World AIDS day and nearly 4000 red ribbons were given out.

Smoking

This continued to be a priority area for the work of the Unit. Extra funds given specifically to prevent young people from starting smoking or to help addicted smokers stop led to the launch of several new initiatives as summarised in Chapter 3.

The Unit was able to continue to supply a weeks free supply of nicotine patches to anyone who wanted to give up smoking after a visit to their doctor or the Quitline Counsellors and worked in conjunction with the Tourist Board and Jersey Health Promotion Unit to produce the second Guide to Smokefree Eating and Drinking Places which contained over 70 local entries. The lead up to No Smoking day was again very busy. This year the theme was 'Ready Steady Stop' and materials were distributed to nearly 400 different establishments. The Unit was pleased to be able to co-sponsor the purchase of a number of different sports equipment sets for primary schools to encourage children to take up activities other than smoking and the launch was led by Zodiac from the TV Series the 'Gladiators.'

Schools

The Unit worked with the local Secondary schools to implement the second Health Related Behaviour Survey for all the Bailiwicks Year 8 and Year 10 pupils, in conjunction with the Exeter University's Schools Health Education Unit. Each school then received its own results to help develop its Personal, Social and Health Education curriculum. The Island results are now being used as a basis for the Units work in this area. A primary school survey is planned for the early part of 1999.

The Health Promotion Officer attended the newly formed multi-agency Support Group which has representatives from all the agencies which support health education in schools. This provides a useful forum for meeting together and resulted in a large exhibition for school staff on all the Agencies work. The Health Promotion Officer also worked with the Education Department to put on a training day for teachers on the formation of Personal, Social and Health Education policies and supported several individual schools in this work.

Conclusion

The next twelve months promise to be as busy as ever. Smoking will continue to be a high priority, particularly in the work with young people and alcohol and the promotion of sensible drinking will also be highlighted. Plans for the Autumn include the launch of the 1998 Healthy Lifestyle Survey which will ask 1,500 residents their views on all aspects of their health. Results of the survey should be available in Spring 1999 and these will point the way forward for the work of the Unit.

Yvonne Le Page
Health Promotion Officer

Chapter 6

Sexual Health and Communicable Disease Control

- **Contraceptions Unplanned Pregnancy and Abortion**

In February 1994 the Board of Health established a working party to examine the above issues. After taking comprehensive evidence, a discussion document was published in November 1995, which in turn led to a policy letter on *'Contraception, Unplanned Pregnancy and Abortion'* in May 1996 [Billet d'Etat VIII 1996].

The starting point and consistent theme across these various stages was the belief that *'Ideally all pregnancies in the Bailiwick should be wanted, and all babies born into a supportive and caring environment'.*

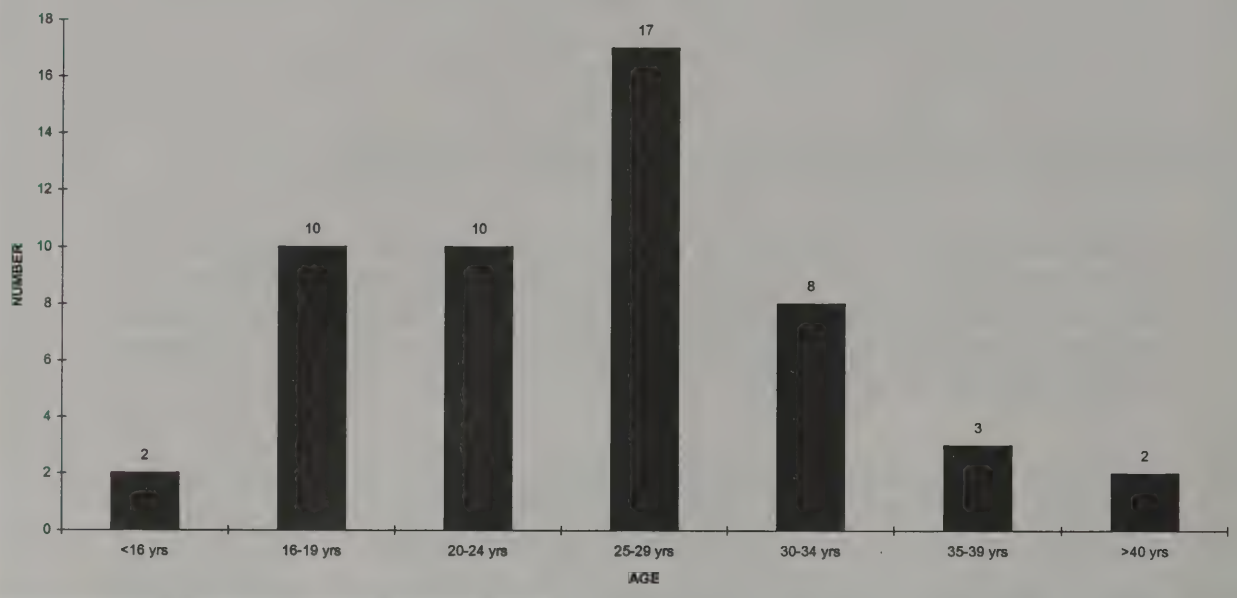
The majority of the Board accepted that *'that on the evidence presented, it is effective education, adequate availability of contraception, counselling, support, legal protection of employment for pregnant women, a statutory maternity provision and adoption opportunities, rather than repressive laws which do most to reduce unplanned and unwanted pregnancies.'*

The Board therefore proposed a package of measures intended to address many of these issues. These included measures: to;

- Allow additional funding to the States Education Council to appoint a third Complementary Health Educator [appointed February 1998].
- Increase funding to allow the Guernsey Family Planning Clinic to relocate, and to increase its work, particularly amongst younger women and girls.
- Give further consideration to various social, legal, and financial matters which may influence women whether to proceed with a pregnancy.
- Ensure that impartial and independent counselling was available to women with an unplanned pregnancy.
- Repeal Guernsey's *'Loi sur l'avortment'* [1910] and replace this with more up to date legislation.

Figure 6.1

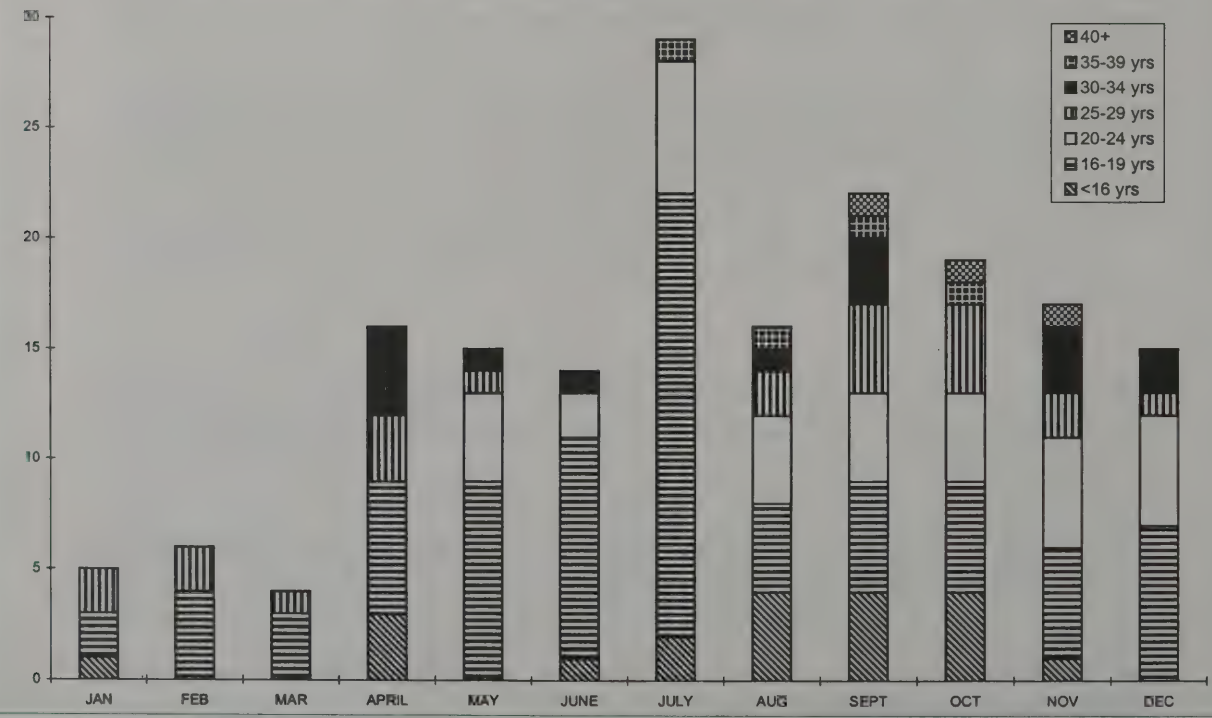
GUERNSEY FAMILY PLANNING CLINIC - COUNSELLOR REFERRALS BY AGE; MARCH-DECEMBER 1997



Source: Guernsey Family Planning Clinic

Figure 6.2

GUERNSEY FAMILY PLANNING CLINIC MONTHLY ATTENDANCE 1997 NEW CLIENTS BY AGE



Guernsey Family Planning Clinic

Following the recommendations of the Billet d'Etat VIII 1996, the Guernsey Family Planning Clinic received additional funding to expand the service and has also now taken on a part-time co-ordinator, and a qualified counsellor.

The clinic continues to provide a high quality service giving advice on contraception to both males and females. It also works closely with the Complementary Health Educators in the schools, and the Health Promotion Unit to educate young people about sexual health, and to reduce rates of unwanted pregnancy and other undesirable outcomes of sexual activity. There are also close links with the Sexual Health Clinic when further referral is necessary.

A telephone 'helpline' is available throughout the week. A counselling service is also available to those who are unhappy or ambivalent about being pregnant, or who may have other related problems. This service allows the client to clarify their feelings, and to explore the various options that are open to them. The majority of clients attend through referral from their general practitioner or family planning clinic and are all refereed back to their general practitioner following their visit or visits to the counsellor. Counsellor referrals by age are shown in figure 6.1.

There were a total of 807 visits to the Family Planning Clinic during 1997. These include 175 new clients. Figure 6.2 demonstrates that the clinic is meeting with increasing success in attracting clients in its target age group - the young sexually active. 38 visits were by girls less than 16 years, 299 for girls 16-19 years, and a further 151 for those 20-24 years. Contraception was arranged in 594 cases, and a total 48 pregnancy tests were arranged, of which 6 positive. Of these 4 girls decided to seek termination of pregnancy.

Early indications are that the Family Planning Clinic is successful in ensuring that effective contraception is more readily accessible, and that professional advice and counselling is available for those who are uncertain about whether to continue with a pregnancy.

Mrs Sue Le Page
GFPC Co-ordinator

The Abortion Law [Guernsey] 1997

All recommendations in the Board of Health's Policy Letter on *'Contraception, Unplanned Pregnancy and Abortion'* were eventually agreed by the States. The *"Loi sur l'avortment'* [1910] was duly repealed, and replaced by the Abortion [Guernsey] Law 1997, which came into effect in March 1997.

There is a requirement: *'that accurate and confidential records should be kept of all terminations'*, and that these be notified to the Medical Officer of Health. An undertaking was given at the time the new law was passed that anonymised details of all lawful terminations performed in Guernsey during the previous year would be published in summary form in the Annual MoH Report.

Figure 6.3

GUERNSEY ABORTION LAW - LAWFUL ABORTION BY AGE AND MARITAL STATUS 1997 [N = 57]

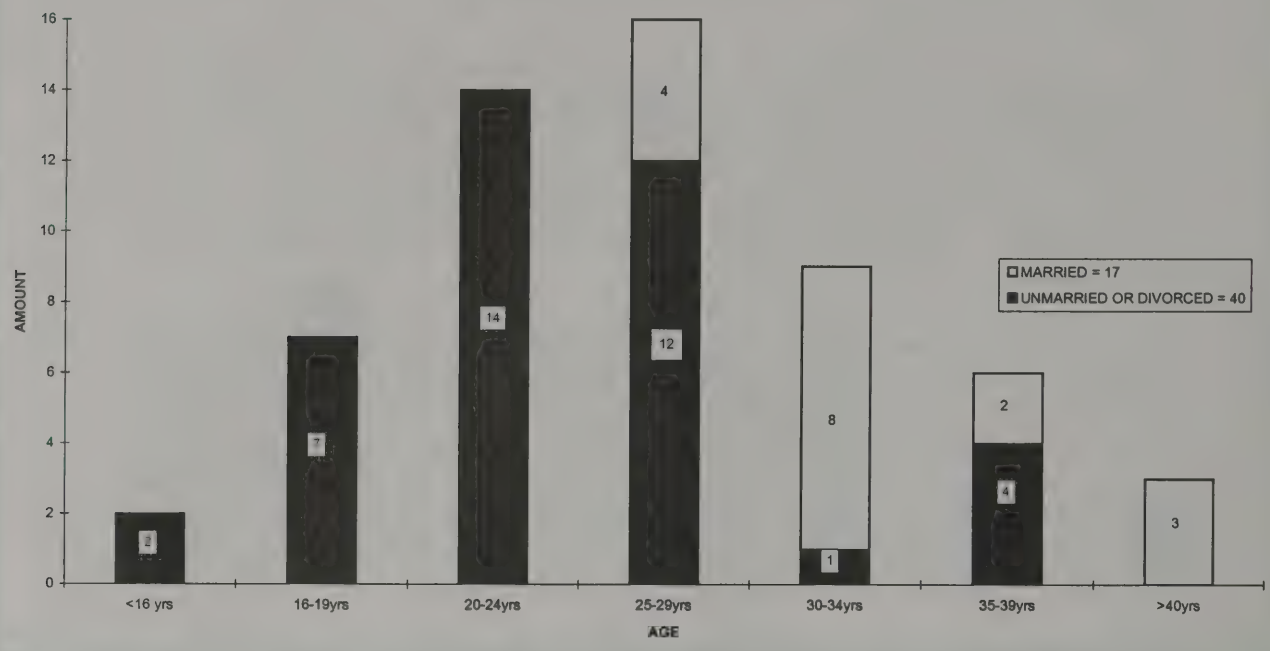
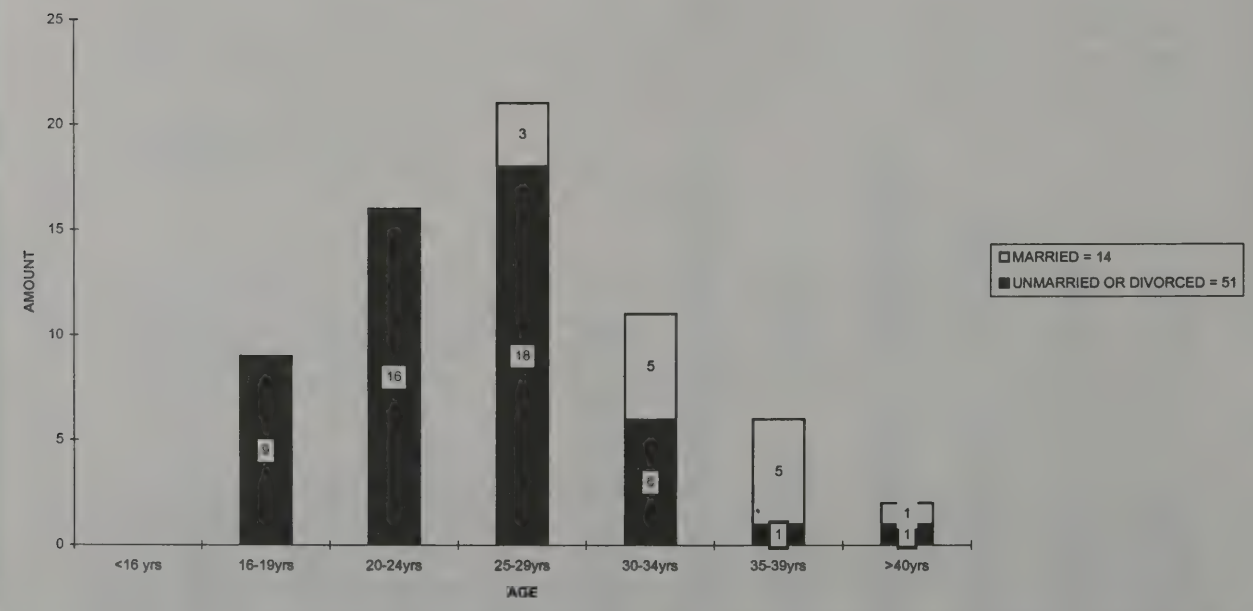


Figure 6.4

ABORTIONS PERFORMED ON KNOWN GUERNSEY RESIDENTS [N = 65] IN ENGLAND AND WALES; BY AGE AND MARITAL STATUS 1997



Abortions in Guernsey and UK 1997

Between March and December 1997, there was a total of 57 lawful abortions performed in Guernsey, an average of 5.7 per month [range 2-9 per month]. Of these, all but 3 had an estimated gestation of less than 12 weeks, with a significant number [29 or 51 %] being performed before 8 weeks of pregnancy. Age and marital status are summarised in figure 6.3. In addition, details obtained from the Office of National Statistics in England show that a further 69 terminations of pregnancy were lawfully performed in England and Wales during 1997. Of these 62 [90%] had an estimated gestation of less than 12 weeks, with 31 [45%] being performed before 8 weeks of pregnancy.

Lawful abortions performed during 1997 on Guernsey residents in England and Wales by age and marital status are shown in figure 6.4. It is of interest to note that there is a similar age/marital status profile between terminations lawfully performed in Guernsey, and those performed in England and Wales. This suggests that the decision to seek an abortion off island is probably made for personal and social, rather than medical reasons.

In total therefore, there were 128 abortions performed on Guernsey residents - either in Guernsey [57] or in the UK [69]. This is a rate of 8.2 per 1,000 Guernsey women aged 14-49, compared with a reported rate of 13.1 per 1,000 women aged 14-49 in England and Wales. It is possible that a certain number of women seeking a lawful abortion in Britain may have preferred to give a UK address rather than a Guernsey address, and that numbers from this source may therefore be underestimated.

Trends in Abortion Rates

Evidence presented in the discussion document '*Contraception, Unplanned Pregnancy and Abortion*' showed that there were 641 lawful abortions performed on known Guernsey residents in Britain between 1990-1994, an average of approximately 128 per year. Contrary to fears expressed at the time of the 'Abortion debate', the legalisation of abortion in Guernsey has therefore not led to any apparent increase in the total number of terminations performed. It is obviously hoped that the efforts of family practitioners and the Family Planning Clinic in promoting effective contraception will in time help reduce the number of unplanned and unwanted pregnancies even further in the future.

It must be noted that the number of lawful terminations performed in Guernsey related to a nine month period. The figures from the Office of National Statistics suggests that from March 1997 when abortion became lawful in Guernsey, approximately equal numbers of abortions were performed on Guernsey, and on Guernsey women in Britain. The Board of Health originally predicted that perhaps one third of women seeking a termination might choose to have this performed in Britain, with the remainder preferring to have an abortion in Guernsey.

SEXUALLY HEALTH CLINIC
SEXUALLY TRANSMITTED DISEASES
ANNUAL STATISTICS 1997

DISEASE	MALE	FEMALE	TOTAL 1997	TOTAL 1996
Gonorrhoea	2	1	**3**	5
Syphilis	4	2	**6**	3
N.S.U./Chlamydia/ Chlamydia contact	34	29	**63**	44
Pelvic Inflammatory Diesease [PID]	n/a	8	**8**	
Herpes Genitalis	15	17	**32**	44
Candida Infection	10	17	**27**	71
Hepatitis B	0	0	**0**	0
Hepatitis C	1	1	**2**	2
Human Papilloma Virus	40	30	**70**	82
Pubic Lice/Scabies	3	1	**4**	13
Gardenerella Vaginalis	0	9	**9**	18
Trichomonas Vaginalis	0	0	**0**	0
Cervical Smears	n/a	31	**31**	27
Counselling	70	60	**130**	149
HIV Blood Testing	65	50	**115**	100
STD Screening	103	63	**166**	160
HIV Aids	7	1	**8**	
TOTALS				
New Patients	178	125	**303**	187
Attendances	506	432	**938**	568

Some women may seek a termination in the UK for family reasons, or the desire for confidentiality. However, a number people attending the Family Planning Clinic have stated that the costs of a 'private abortion' in Guernsey compare unfavourably with those in the UK, [even taking into account the additional cost of air fares and accommodation. This is a matter which the Board of Health intends to keep under review.

Sexual Health Clinic

There has been a marked increase in total attendances at the Sexual Health Clinic during 1997. It has become more difficult to adequately manage this workload on the existing premises and with existing staffing levels. A detailed bid for development of the sexual and reproductive health clinics was considered by the Board of Health early in 1998. This proposed plans for the further development of the sexual health clinic to better achieve the objectives contained in the 1992 White Paper *'The Health of the Nation'*. These proposed:

- To reduce incidence of HIV infection
- To reduce the incidence of other sexual transmitted diseases
- To further develop and strengthen monitoring and surveillance of sexually transmitted disease.
- To provide effective services for the diagnosis and treatment of HIV and other STD's.
- To reduce the number of unwanted preganancies.
- To ensure the provision of effective family planning services for those who want them.

Achieving these objectives will require substantial development of the existing services with investment in personnel, training, IT, new premises, and adequate operational funding.

• Trends in Sexually Transmitted Diseases

The general trends for sexual diseases in Guernsey are similar to the United Kingdom. However, there has been a worrying increase in cases of syphilis. Three of these were early syphilis, whilst the remainder were detected as a rsult of routine antenatal and blood donor screening.

Therer were no new cases of HIV in 1997. There are seven patients who are currently under regular review and are on combimation antiretroviral therapy. Two of these patients are on Highly Active Retroviral Therapy which includes dual protease regimes.

Report to the Department of Health
Notification of Infectious Diseases 1997

						1997 (Quarters)				
	1992	*1993*	*1994*	*1995*	*1996*	*1st*	*2nd*	*3rd*	*4th*	Total
Measles	0	2	1	1	2	**0**	**0**	**0**	**0**	**0**
***Mumps**	0	1	0	0	0	**0**	**0**	**0**	**0**	**0**
***Rubella**	0	4	0	4	6	**0**	**0**	**0**	**0**	**0**
Whooping Cough	2	0	4	6	0	**0**	**0**	**0**	**0**	**0**
****Food Poisoning**	168	248	140	138	160	**22**	**40**	**59**	**50**	**171**
Hepatitis A	0	0	0	1	0	**0**	**0**	**2**	**0**	**2**
Hepatitis B	1	2	0	2	0	**0**	**0**	**1**	**1**	**2**
Hepatitis C	0	0	0	0	1	**0**	**0**	**0**	**0**	**0**
Meningitis	1	2	1	4	4	**0**	**0**	**2**	**1**	**3**
Tuberculosis	1	2	4	6	5	**0**	**0**	**1**	**0**	**1**
Malaria	1	0	0	0	0	**0**	**0**	**0**	**0**	**0**
AIDS - notified annually	0	0	0	0	0	**0**	**0**	**0**	**0**	**1**
Scarlet Fever	2	1	1	1	1	**0**	**0**	**0**	**0**	**0**
Psittacosis	0	0	0	5	0	**0**	**0**	**0**	**0**	**0**
Dysentery	0	2	0	0	0	**0**	**0**	**0**	**0**	**0**
Q Fever						**0**	**0**	**0**	**2**	**2**
Carriers of HIV Antibody - notified annually	0	1	5	1	1					
HIV Prevelence - notified annually										**8**

* Mumps and Rubella became notifiable in Guernsey on 1.1.89

** Formal notified and informal notified cases have been combined

There has been a significant increase in the number of GP referrals to the Clinic, which reflects the continuing importance of partner notification and contact tracing. The majority of patients requesting HIV testing are at greater risk of other STDs compared with the general population. It is therefore sensible that they are seen at the GUM Clinic, where they can be offered full STD screening, and conselling on safer sexual practises, and all blood tests will be coded to ensure confidentiality.

- ***Chlamydia Trachomatis***

Over the last two years, a great deal of data and research has been published on Chlamydia - the most common bacterial STD in the devloped world. At the end of 1997, a report from the Chief Medical Officers Expert Advisory Group on *Chlamydia Trachomatis* was published, along with clinical guidelines and standards for genital Chlamydia infection produced by the Central Audit Group in Genito-Urinary Medicine. Both these groups reported on the importance of Chlamydia infection, its correct management, and identified 'at risk' groups for targeted screening.

All patients with a positive Chlamydia test should be referred to the Genito-Urinary Medicine clinic for further management, including appropriate test of cure and contact tracing. Targeted screening for Chlamydia by gynaecologists, family prectitioners, and family planning staff will also result in increased detection rates. It is recognised however that the current laboratory methods used to identify Chlamydia are unsatisfactory, resulting in only a 60% sensitivity [ie 40% of true cases reamin undiagnosed]. *Chlamydia* denital infection is symptomless in 50% of men and 60% of women.

The introduction of newer less invasive tests such as the Polymerase Chain Reaction [PCR] or Ligase Chain Reaction [LCR] test performed on urine samples are a more acceptable method of screening for amongst symptomless people, and also offer a higher detection rate because of their much incresed sensitivity. In addition to targeted screening, *Chalmydia* testing should be offered to symptomatic grounds regardless of age or any other factors. A more detailed protocol for *Chalmydia* screening is being considered by the Sexual Health Forum, in conjunction with primary care physicians, gynaecologists, and family planning.

Better diagnosis from targeted screening and better testing of symptomatic individuals requires better notification and contact tracing. Adequate levels of staffing and resourcing are essential to achieve this.

Dr Nick King
Physician - Sexual Health Clinic

Communicable Disease Control

With the exception of food poisoning, which still remains a problem, most other notifications of infectious diseases have continued to decline, and again in 1997 are at an historical all time low.

The sudden onset and sometime fatal consequences associated with meningococcal disease remains a cause for public concern and media interest. Most cases are however so called 'sporadic cases' and although household and close personal contacts are normally offered prophylactic antibiotics, with vaccination in the case of proven infection with A and C strains of the disease, no further public health action is generally necessary.

Population prevalence studies suggest that 10% of the adult population, and up to 25% of children and young adults may be carriers of meningococcus at any one time, and that this population is continually changing.

The reason why overt disease develops in individuals whilst the majority of the population remain symptomless carriers appears to have more to do with falls in an individuals immunity, rather than any change in the virulence of the organism. A high degree of awareness of the early symptoms of the disease and urgent treatment in all suspected cases seem to offer the best protection against avoidable meningococcal morbidity and mortality.

The single case of tuberculosis notified in the third quarter of the year was not confirmed as tuberculosis on laboratory testing. The two cases of Q fever were not connected.

Dr Brian Parkin
Deputy Medical Officer of Health

Chapter 7

Occupational Health

Introduction

The work in the Occupational Health Department has continued to be varied with the emphasis being the prevention of work related ill health and accidents.

The major event of 1997 was the opening of the Occupational Health suite in November. The suite is located on the second level of the Princess Elizabeth Hospital. The extra space allows for an office, consultation room, with a waiting room and toilet facilities. This has meant employees can be seen in a more confidential and efficient environment. An information leaflet about the unit has also been published and distributed for all the Board of Health staff.

The service was also delighted to be able to welcome a new member of staff Mrs Jackie Mallett as receptionist/secretary to the department. Mrs Mallett joined the department in July and has already had a great impact in the smooth co-ordination of the administration and secretarial side of the Occupational Health Service.

- **Monitoring work related ill health**

The Princess Elizabeth Nursing Administrator has provided data on all sickness absence from all the wards and departments. This has been analysed and a graphical representation made for each ward. This has highlighted the peaks and troughs in recorded absence. The Occupational Health Nurse [OHN] has then been able to investigate the cause of unusual results with the intention of exploring the cause of the absence and offering the appropriate advice to the line manager to reduce avoidable sickness absence.

The OHN attended a "Managing Absence" training day held at the Civil Service Board. This was also attended by the line managers of a variety of departments from the Board of Health.

- **Health promotion and prevention**

The OHN has encouraged the Princess Elizabeth Hospital's Health and Safety representatives, while attending their monthly meetings, to raise the profile of Health and Safety in their respective work areas with the aim of minimising the risk of work related accidents or ill health to employees. The Annual European Health and Safety week is normally held in October and it was decided to hold our own similar event. There was a competition for the best Health & Safety idea and the OHN was on the judging panel. There were some excellent ideas and plans to implement these were put into place following the competition. An exhibition was held in the New Meeting room. This included; photographs of the risk assessment that the Health & Safety representatives had performed with the improvements made, health awareness posters, and Health and safety materials including a display personal protective equipment.

• Implementing immunisation programmes in the workplace

Since our move to the Princess Elizabeth Hospital site there has been an increased uptake of work related Hepatitis B immunisation. This has been due to the OHN promoting the service and the clinic sessions being more accessible. The immunisations are being recorded on the OPAS software. One of the main benefits of on-site vaccinations is the flexibility for the OHN being available for the different shift patterns of the employees. This has reduced the amount of appointment's not attended due to unpredictable busy times of the employees workload. It is planned to provide a similar on site service at the Castel Hospital during 1998.

• Visit to Mignot Memorial Hospital in Alderney.

The Occupational Health Nurse was made to feel very welcome during the first and subsequent visits to Alderney. During the time spent at the Hospital most of the employees have now met with the Occupational Health Nurse. One of the outcomes of the health needs analysis of the employees is work related health promotion and vaccinations. Plans for this are already in progress as an objective for 1998.

• Objectives for 1998

These have been set as follows:

- To continue to collate and analyse data on sickness absence, and to recommend and implement such measures as will reduce avoidable sickness absence.

- To train identified Registered Nurses at the Mignot Memorial Hospital in Alderney to implement a work related vaccination programme for Board of Health employees.

- To further develop worksite visits to other Board of Health premises.

- To further develop awareness of post exposure prophalixis treatment, following an exposure to blood borne viruses, through the implementation of the Sharps Injury Policy.

- To work with the Fire, Health and Safety Advisor to promote work place hazard awareness amongst employees through training, information giving, and instruction.

Mrs Pam Smith
Occupational Health Nurse

Report of Fire, Health and Safety Advisor

Introduction.

1997 saw a major increase in the awareness of Board of Health staff regards Health and Safety requirements. The presence of a full time Health and Safety Adviser helped concentrate thinking, as well as provide an identifiable resource on Fire, Health and Safety requirements.

Health and Safety and Occupational Health issues often overlap and during 1997 a close working relationship between the disciplines has been achieved.

Fire safety and education

Inspections of Board of Health properties by the Fire Brigade during 1997 highlighted the improvements all directorates had made in Fire safety and housekeeping, with many fewer problems being identified.

Training in conjunction with the Guernsey Fire Brigade resulted in 860 employees attending either a 'Fire One' (basic) or 'Fire Two' (Fire extinguisher - hands on) lecture.

A first 'Fire Three' study day was also successfully held with 11 members of the Portering and Catering departments taking part and gaining experience in tackling larger fires, by using the Fire Brigades training rig situated at Guernsey Airport.

Accident and incident reporting

Accident and incident reporting was introduced in September 1997 and the co-operation of staff in providing accurate and detailed information has contributed enormously to the successful development in this initiative.

Even with only a few months statistics to analyse it has been possible to detect trends, identify problem areas and implement procedures to help prevent future reoccurrence. It is expected that the number of reported accidents/incidents will increase as staff become familiar with the system, although it is hoped their severity will decline.

The comparison of 1998's statistics with National and NHS averages and costing will be possible.

Risk Management

By its very nature, health care is a risk activity, indeed heath care professionals should not be discouraged from taking some risk in developing more effective methods of treatment and care for patients and clients.

It is however important that such risks are taken as a result of a positive decision to do so, on the basis of good information and it is for these reasons that the Board of Health have invested in training for members of staff in General Risk Management, Manual Handling and Control of Substances Hazardous to Health (COSHH).

The 2 day courses and the subsequent follow up sessions was felt to have been successful and the Board of Health now have:-

- 64 General Risk Assessors
- 26 COSHH Assessors
- 16 Manual Handling Assessors

Walkthroughs and risk assessments were conducted throughout 1997, as Risk Assessors meet regularly with the Fire Health and Safety Adviser to discuss any areas that require further intervention.

Health and safety training

All new employees with the Board of Health now receive Health and Safety, and Fire training as part of their induction programme ensuring that they are aware of policies and procedures related to their new role.

During 1998 Health and Safety training will be offered to all departments to raise awareness of potential hazards and how to deal with them

Candice Smith
Acting Fire, Health and Safety Advisor

Health and Safety Working Group

Background

The Health & Safety Working Group has been given the responsibility to implement the Board's Health & Safety Policy which was adopted in March 1994.

Objectives for 1997

The Working Group identified three objectives for 1997 as follows:

- **Developing a system for the collation of data in order trends may be identified and risk reduction may take place.**

The accident and incident reporting system is now in place and will come fully on line by the beginning of 1998. The data collected provides us with the opportunity to identify risk prior to occurrence and monitor areas where there may be concern. This will improve and become more valuable as more data is collected.

- **Increasing departmental awareness of Health and Safety Requirements.**

With the culture change throughout the Board and the Kings Fund influence, awareness has most certainly improved especially in clinical areas. The presence of a full time Safety Advisor has concentrated thinking and improved awareness.

- **Occupational Health Policy on Sickness and Absence.**

This policy continues to be developed but the lack of formal data collection needs to be addressed. This will continue to be an objective for 1998

It will be noted from the Fire, Health and Safety Advisor's Report that all three objectives for 1997 have been successfully achieved.

- **Adapting to meet the future**

The Health and Safety 'landscape' has changed considerably during the five years in which the Health and Safety Working Group has been in existence. Some of these changes the Health and Safety Working Group has itself contributed to, or brought about, whilst others are part of a wider change in awareness of, and approaches to these issues.

Foremost amongst these is the developed concept of 'risk management'. This was touched on briefly in last years Annual Report, and in the twelve months since, the concept has been further accepted across all Board of Health sites, and throughout the Board's activities.

Although effective health and safety must adopt a 'risk management' approach, risk management is a far wider and more comprehensive concept. In order to ensure that this wider approach continues to be understood and implemented, a number of changes are predicted for 1998 and beyond. These will include:

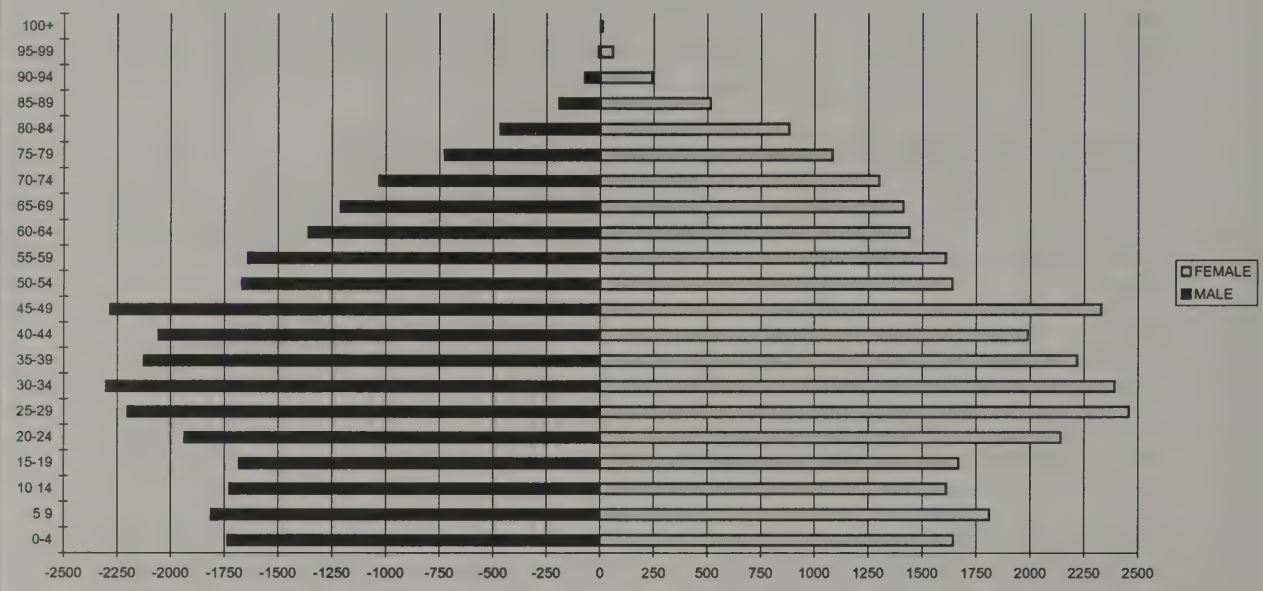
- An updated 'Board of Health', Health and Safety Policy
- Restructuring of the Health and Safety Working Group
- Clarification of accountability and lines of reporting and responsibility
- Continuing development of 'clinical risk management' under the 'clinical governance' umbrella

These changes are intended to be implemented in the later part of 1998 and early part of 1 999, and progress will be detailed in the next Annual MoH Report.

Dr David Jeffs
Chairman 1994-98
Health and Safety Working Group

Figure 8.1

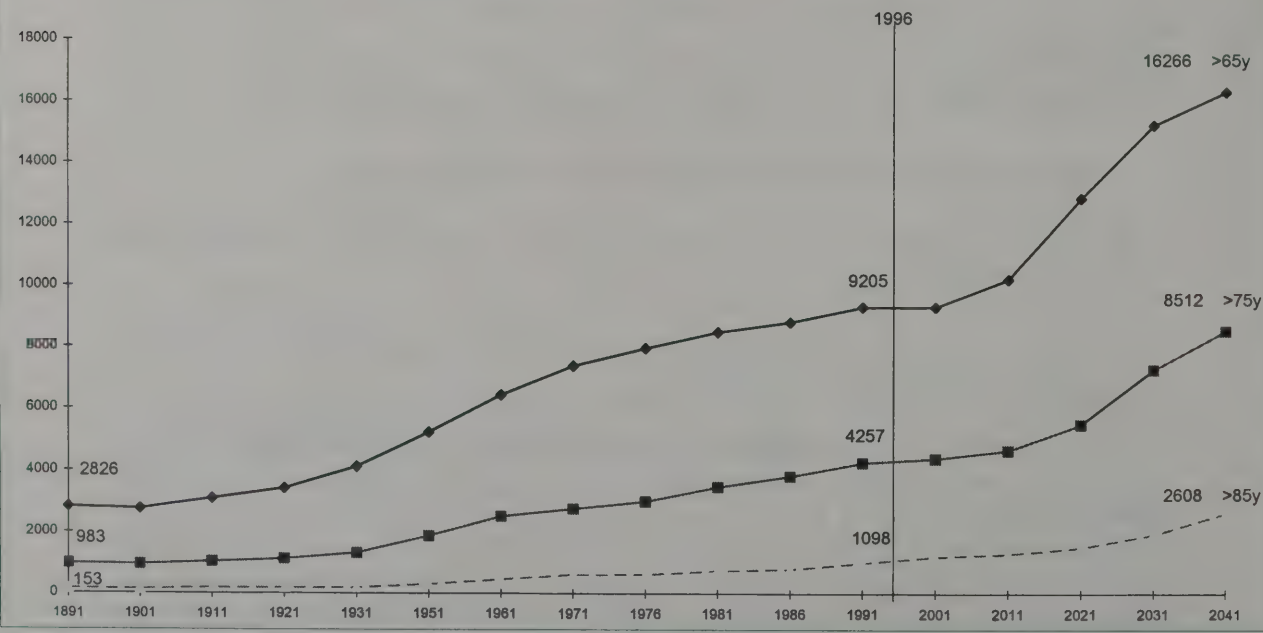
AGE/SEX "PYRAMID" - GUERNSEY CENSUS 1996



Source: Guernsey Census 1996

Figure 8.2

INCREASE AND PROJECTED INCREASE - OLDER PERSONS: GUERNSEY 1891-2041



Source: Economics & Statistics Unit A&F 1998

Chapter 8

The health of older Guernsey

'Population ageing represents a triumph of social development and public health'.

'Epidemiology in Old Age' **BMJ/WHO 1996**

- ***Ageing 'Baby Boomers'***

In Guernsey, as in much of the rest of the western world, the bulge in the 'population pyramid' which represents the children of the postwar 'baby boom' have already entered middle age, or will shortly do so. [Figure 8.1]

In some ten years time, the oldest of these 'baby boomers' will reach retirement age, and for the next 40 years, the proportion of old [> 65 years], and very old people [> 85 years] in Guernsey's population will rise to previously unprecedented levels, before beginning to decline again in the middle years of the next century.

The 'greying of Guernsey' has implications for housing, healthcare, transport strategy, the provision of pensions, the size of the economically active workforce, and the prosperity and well being of the island more generally. This Chapter seeks to provide a public health perspective on these important issues.

Reasons for an ageing population

Figure 8.2 demonstrates that the numbers of the old [>65 years] and the very old [>85 years] in our population has been rising steadily for at least 100 years.

This has been brought about by a change from a traditional pattern of high mortality [concentrated mainly in infancy and childhood], but accompanied by high fertility, to one of low mortality [at all ages] accompanied by low fertility, which is now characteristic of 'westernised societies'. This change in population structure is known as 'demographic shift'.

Some responses to 'demographic shift'

Guernsey is not alone in its concern about the consequences of demographic shift. Over 70% of people turning 65 years now live in developing countries, and population ageing is increasingly being seen as a global problem.

- In 1995, the World Health Organisation [WHO] initiated a new programme *'Ageing and Health'* to address this issue world-wide.
- In 1996, the BMJ Publishing Group, in collaboration with WHO published a comprehensive review *'Epidemiology in Old* Age'. This takes a public health perspective, and places the epidemiology of Britains ageing population in global context.

- In 1996 'Age Concern' launched what it calls the *'Millennium Debate of the Age'*.

This aims to raise awareness of how society will change, and propose policies to address this over the next 50 years. It is described as *'the biggest public debate ever to happen outside government... in many ways it will be a debate about the future of Britain'* The debate will be progressed in a variety of forums, including through market research, the media, exhibitions, conferences, competitions, citizen juries, and its own web site - *www.ge2000.org.uk.*

- A Royal Commission on *'Long Term Care of the Elderly'* was established in 1997.

- The WHO have designated the last year of this century [1999] as the *'international year of older persons'*

Responding to an ageing population in Guernsey

The likely effects of the 'demographic timebomb' in Guernsey have also been the subject of much debate. Recent initiatives undertaken in Guernsey which are relevant to the challenges of an ageing population include:

- **'Older Persons Care Strategy'** produced by the Older Persons Service Planning Group of the Board of Health.

- **Board of Health Report** *'Strategic Options for the Care of Older People'* [to be published shortly].

- **Revised *'Residential and Nursing Home Legislation'*** for the Board of Health due to go to the States next year.

- Work by the **Guernsey Social Security Authority** and the [UK] **Government Actuary** on the economic and financial consequences of an increasing proportion of 'economically inactive' persons in the population.

- A discussion paper *'Policy for old age: the next 40 years'* prepared by Advisor in Social Policy, Dr Paul Spicker for Advisory and Finance, and commenting largely on Guernsey's inappropriate housing mix.

- Report of the **'Working Party on the Provision and Funding of Long-term Care'** prepared by the officers of the Guernsey Social Security Authority in collaboration with the States Board of Health, States Housing Authority, and Policy Analysts, Advisory and Finance Committee. The full report is expected to be published in the autumn 1998.

- Work undertaken by the **Economics and Statistics Unit,** Advisory and Finance Committee on likely changes in population structure and life expectancy, based on UK mortality on present migration data.

- Important associated work includes possible economic incentives to encourage older people who wish to continue in paid employment after normal 'retirement' age to be able to do so. Not only does this reduce the overall 'dependency level' of older people in the community, but there are also health benefits for many in continuing to work even in a part-time capacity.

How urgent is the problem?

As shown in Figure 8.2, the rate of increase in the proportion of older people in Guernsey will follow existing trends for the next 15 years or so, and there will even be a small decrease in the proportion of older people during this time.

From around the year 2011, the number of persons above retirement age [> 65 years] in Guernsey will begin to rise sharply, with an increase in both the numbers and overall proportion of the very elderly [those 85 years and over] following some few years later. These changes are summarised in Figures 8.3 and 8.4.

This predicted 'demographic' shift in Guernsey's population has two main components. Firstly there has been an overall increase in life expectancy ie more people are successfully reaching old age. The second component is that of all those reaching old age, an increasing proportion will live to become 'very elderly'.

As stated in the last Annual MoH Report [1996/97] *'In the Guernsey context, the demographic timebomb may be real enough, but it does have a fairly long fuse'. There is the need to use this longer lead time to plan and implement the best mix of health and support services to meet the likely health needs of older residents when this time comes'.*

Life expectancy in Guernsey

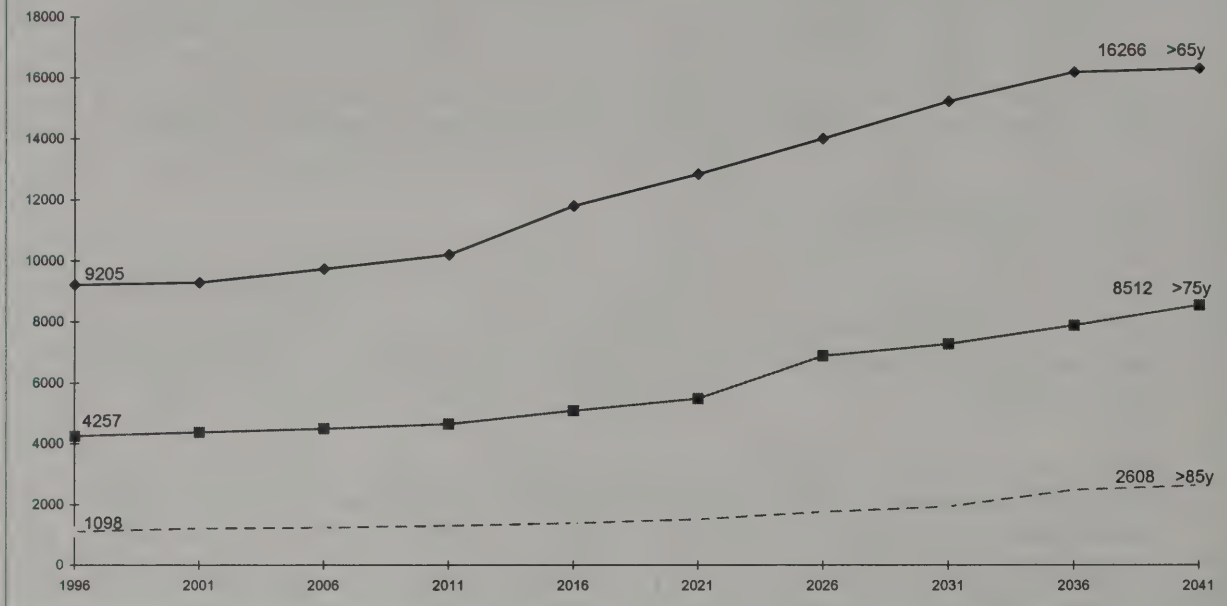
The overall increase in life expectancy is dramatically illustrated by British figures. In 1840, only 18% of Britons reached the age of 75 years, whereas today 66% of people born in the British Isles are likely to reach this age.

At the turn of the century, life expectancy in Guernsey was probably somewhat less than in Britain - certainly high levels of premature mortality on the Island drew comment at that time. However inadequate records make exact calculations difficult.

More recent data [derived from Guernsey deaths 1985-87 compared with English Life Table 14] suggests that life expectancy for men in Guernsey now exceeds the average in England by a significant 2.2 years at birth and 0.9 years at 75 years, and for women by 1.6 years at birth, falling to 1.3 years at 75 years of age.

Figure 8.3

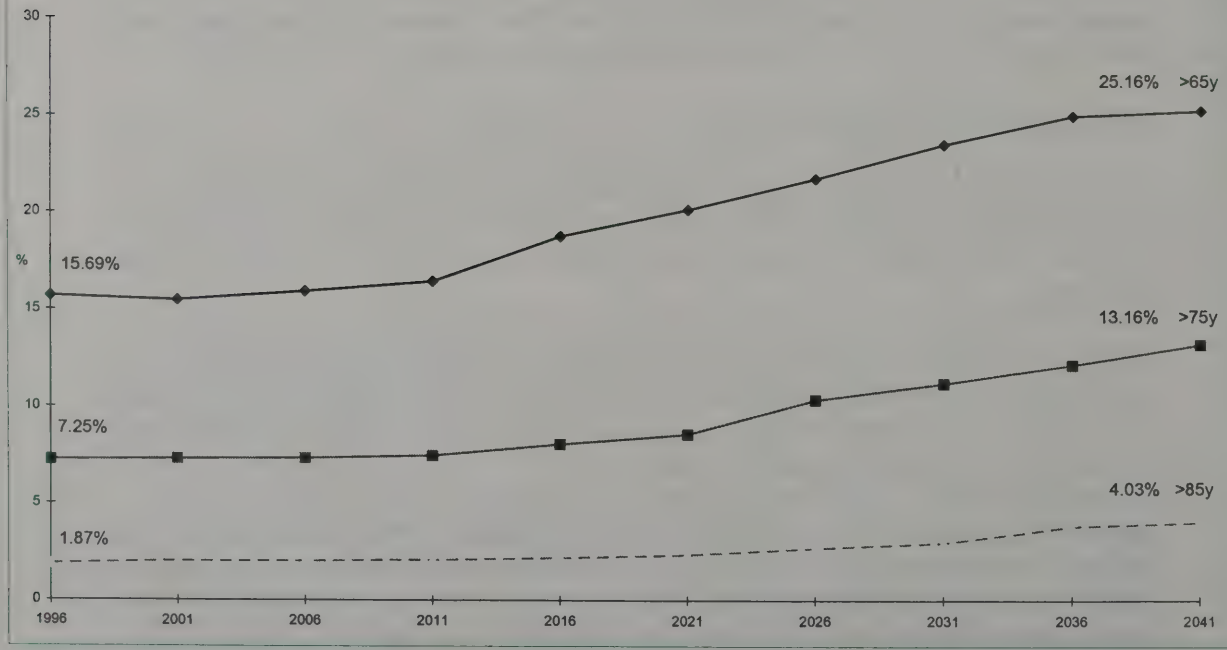
PROJECTED INCREASE BY NUMBER OLDER GUERNSEY PERSONS 1996-2041



Source: Economics & Statistics Unit A&F 1998

Figure 8.4

PROJECTED INCREASE BY % OLDER GUERNSEY PERSONS 1996-2041



Source: Economics & Statistics Unit A&F 1998

Observed Life Expectancy - England and Guernsey compared: 1985-87

	Age Attained	England ELT14	Guernsey 1985-1987	Difference
Males	0	71.0	73.2	+2.2y
	25	72.7	74.9	+2.2y
	50	74.3	76.1	+1.8y
	75	82.7	83.6	+0.9y
Females	0	77.0	78.6	+1.6y
	25	78.2	79.9	+1.7y
	50	79.4	81.1	+1.7y
	75	85.2	86.5	+1.3y

Source: *Channel Islands Actuarial Society 1990*

Guernsey life expectancy is currently being recalculated using mortality data for 1995-97 and population data from the 1996 Census. It is predicted that these new calculations will show an even greater difference between life expectancy in Guernsey at birth, at 15 years [end of schooling], and at 65 years [retirement age] for both men and women, compared with the English population overall. This recalculated data should be available in 1999.

As well as greater life expectancy at all ages, more older people will live to very old, and extreme old age. In Britain in 1951, for example, only 300 people were aged over 100. In 1997, there were 3,000 and by 2010, it is predicted that over 20,000 people will be aged 100 or more. At the time of the most recent Census data in 1996, Guernsey had 9 females [0.03% of the population] aged over 100. Those dying over the age 100 numbered 5 in 1995, 6 in 1996, and 8 in 1997. Extreme longevity is obviously becoming more common.

Does more ageing mean more ill health?

A popular view holds that old age and increasing ill health are inseparable, and that an increase in the number and proportion of older people in the population must inevitably put increasing strain on both health and social services, and on society more generally as it struggles to cope with a huge burden of chronic ill health amongst the elderly.

The alternative view proposed by the Word Health Organisation and the World Bank amongst others, is that population ageing represents a triumph of social development and public health, and that from a demographic perspective, *'the view of ageing as a crisis must be rejected since healthy ageing is clearly possible'*.

These two conflicting view points may be summarised as follows:

'Pessimists have argued that the ageing in the population will accompanied by a pandemic of degenerative diseases and chronic mental disorders as medical and surgicall innovations enable an increasing proportion of the unfit to survive'. [Kramer 1980]

The alternative view holds:

'Optimists hold that the adoption of healthy lifestyle and scientific advances will result in the compression of morbidity into an increasing brief period before death'. [Fries 1980]

Do we have grounds for optimism or pessimism when we consider ageing and health in Guernsey'? A number of factors must be considered when planning healthcare for older persons in Guernsey, once numbers of the elderly and very elderly start to increase early in the next century. These include:

- The 'era of birth' effect
- The influence of affluence on health
- The 'compression of morbidity' and 'healthy life expectancy'
- The likely impact of technology on patterns of illness in old age
- Opportunities for health promotion in the older age group

The 'era of birth' effect

The rising life expectancy at birth in Britain over the past 100 years may be briefly summarised as follows.

Expectation of Life at Birth [years] - England and Wales 1891 - 1993

Period	Males	Females
1891 - 1900	44.1	47.8
1950 - 1952	66.4	71.5
1991 - 1993	73.7	79.1

Source: OPCS *Mortality Statistics Series* DHl

This increase in life expectancy at birth has been far more influenced by medical and social provisions around birth and childhood, rather than by medical and social care in older age.

For example, those dying in Britain 1891 - 1900 aged 44 - 48 years had generally been born in 1840 - 1850, and had grown up before the worst excesses of the Industrial Revolution had been ameliorated by early public health reforms, leading to the first Public Health Act 1948.

Similarly those dying in 1950 - 1952 aged 66 - 72 years had generally been born in the later decades of the 19th century, when public health and preventative measures were firmly established, but advances in curative medicine were [generally] yet to come. Equally, those dying 1991 - 1993 aged 74 - 79 years had generally grown up before and during the First World War and in the 1920's, which were for many a time of depression and economic hardship.

In contrast, those reaching older age in the years ahead [2011 onwards] will generally have grown up in the more affluent 1950's and 1960's.

Just as proxies for physical health, such as average height for both men and women have increased markedly over the past 40 years, so it may be predicted that adverse factors during pregnancy and childhood, which are likely to impact adversely on health in later life, will also be markedly reduced in this generation.

The influence of affluence on health

As well as an increase in life expectancy over the decades, it can be demonstrated that there is gradient in life expectancy between the least and most affluent. This effect is apparent for both men and women, and this advantage persists into older life.

Social Class Gradient for Life Expectancy at Various Ages - UK 1987 - 1991

	Social Class [UK] IV, V [1987-91]	Social Class [UK] I, II [1987-91]	
LE at birth	**M69.7**	**M74.9**	**+5.2y**
	F76.8	**F80.2**	**+3.4y**
LE age 15 years	**M55.8**	**M60.5**	**+4.7y**
	F62.5	**F65.8**	**+3.3y**
LE at 65 years	**M12.4**	**M15**	**+2.6y**
	F16.7	**F18.7**	**+2.0y**

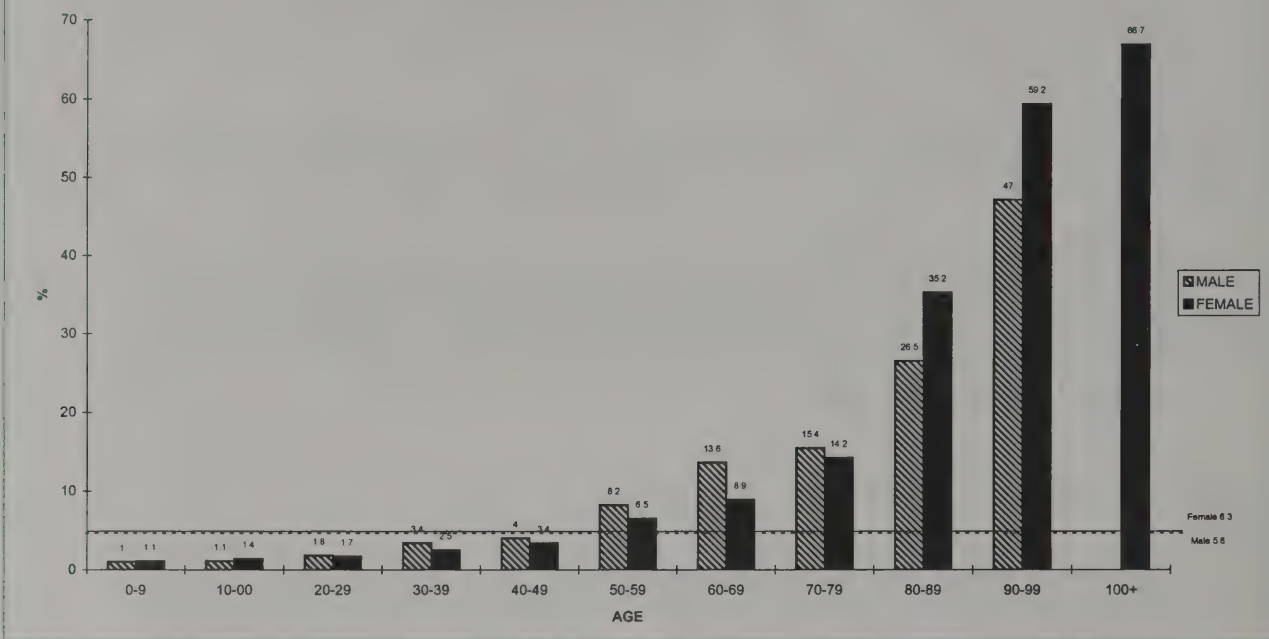
Source: Office of National Statistics *'Health Inequalities' 1994*

As well as a quantifiable improvement in life expectancy across the social gradient, a number of health surveys have also confirmed that better health is generally more common amongst the more affluent.

Although it has not been possible to analyse the results of Guernsey's two *'Healthy Lifestyle'* Surveys carried out in 1988 and 1993 by social class, life expectancy figures.

Figure 8.5

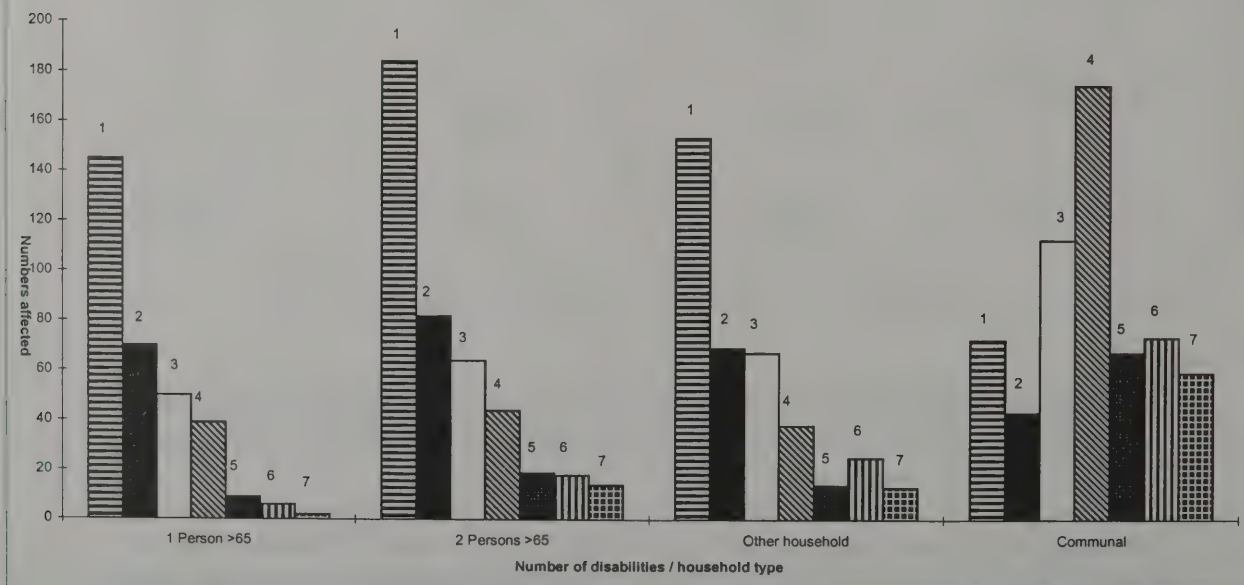
SELF REPORTED DISABILITY BY AGE DECILE GUERNSEY 1996



Source: Guernsey Census 1996

Figure 8.6

**SELF REPORTED DISABILITY;
NUMBERS OF DISABILITIES BY HOUSEHOLD TYPE:
GUERNSEY CENSUS 1996**



Source: Guernsey Census 1996

Although it has not been possible to analyse the results of Guernsey's two *'Healthy Lifestyle'* Surveys carried out in 1988 and 1993 by social class, life expectancy figures in Guernsey equate more closely with those of social classes I, and II in England, rather than social classes IV, and V. The 1996 Census suggests that 59% of the Guernsey population may be classified by occupation and social classes A, B or CI. On this basis, it would be reasonable to assume that the health status amongst Guernsey's more affluent population will also be proportionally better in old age.

'Compression of morbidity'

As life expectancy for greater numbers of the population has increased, attention has turned increasingly to quality of life in later years - sometimes known as *'healthy life expectancy'* or more simply as *'healthy ageing'*.

In recent years, National Census and Household Surveys have tried to estimate more accurately the level of disability and handicap in the community.

For example, the 1991 UK Household Surveys asked, *'Does the person have any long term illness, health problems or handicap which limits the daily activities or the work that a person can do? Include problems that are due to old age'*.

Using data from current Life Tables to calculate life expectancy at different ages, and the proportion of disability self reported in the population at various ages [obtained from Household Survey data] it is possible to calculate an index known as **'Healthy Life Expectancy' [HLE].**

Comparing trends over time, *total average life expectancy* for older persons aged 65 has increased from approximately 13 years in 1976, to 18 years in 1992 - an increase in life expectancy of 5 years over this period.

Over the same period, the number of *disability free years* [equal to 'healthy life expectancy'] has increased from 7 years in 1976 to almost 10 years in 1992. In other words, there has been an increase total life expectancy of 5 years, in healthy life expectancy of 3 years, but also an increase of 2 years in the period in which disability is self reported.

When examining these trends, the Health Select Committee of the House of Commons commented in 1996, *'The projected picture, therefore varies according to which type of data are used and may depend also on changes in people's expectations and habits of self reporting. The effects of such changes are difficult to assess'*.

Healthy life expectancy in Guernsey

The 1996 Guernsey Census for the first time collected data on self reported disability in the community. This showed there were 3,376 adults in Guernsey who identified themselves as disabled on one or more of the criteria used. Applying UK figures to the Guernsey population, it would be expected that around 6,500 Guernsey adults would have reported disability.

The proportion of the population self-reporting disability by age decile is summarised in figure 8.5. It will be noted that the proportion of the population self-reporting disability only begins to rise significantly in the 80-89 years decile, and even in this age group, over 60% of women and 70% of men consider themselves to be free of disability on the parameters assessed.

Where do disabled people live?

Analysis of data on disability and living accommodation extracted from the 1996 Guernsey Census, [figure 8.6] shows that:

- 2,413 people > 65 years live in single person households [ie by themselves], of whom 106 [4.3%] claim to have three or more disabilities, as measured by the Census questions.
- 3,540 people live in a household in which both occupants are > 65 years. Of these, 159 [4.5%] claim three or more disabilities.
- A further 2,360 people > 65 years live in households consisting of three or more people [ie usually with family]. Of these 642 [6.7%] have three or more disabilities.
- 823 people > 65 years live in communal homes or institutions. Of these, 485 [59%] report three or more disabilities and 370 [45%] report four or more disabilities.

It is obviously of concern that over 100 older Guernsey residents with a high level of disability are living by themselves, obviously they must receive some support and assistance to do so. A further 150 with similar levels of disability live in a two person household, where the other person is also > 65 years. If this other person were themselves to become disabled, then remaining at home might become an increasing problem.

However, it would appear that the vast majority of older people with a severe level of disability are probably already appropriately housed in long-term communal or institutional care.

Is there an 'iceberg of hidden morbidity' in the Guernsey population?

This lower than expected rate of self-reported disability in the Guernsey population has stimulated some speculation;

- Is there really a lower level of disability, or just a lower level of reporting?

- Alternatively does the availability of a 'disability allowance' in the UK lead to over-reporting of disability there?

- Is disability less of a liability in a more affluent community? [Not being able to walk to the bus stop is less relevant if you are still able, and can afford to drive].

- Alternatively is there an 'iceberg of hidden morbidity' in the Guernsey population?

The Guernsey 'Health Screening in the Elderly' Project

In the health context, 'screening' is a form of secondary prevention, namely '*the search for a precursor disease in those who do not have symptoms of that disease, and who believe themselves to be free of it*'.
It might be postulated that the need to pay for a consultation might discourage some older people from seeking preventative services. There may, therefore, be an 'iceberg effect', with a greater burden of unrecognised physical and social morbidity amongst this section of the population in Guernsey.

To determine the true level of unrecognised disability in the Guernsey population, the Board of Health is supporting a two stage research project. Firstly a short pre-tested and validated postal questionnaire will be sent to 300 patients aged >75 years and living in their own homes [a statistically robust 7% of this age group]. They will have been randomly selected from the three group practices on the island. Their responses will be evaluated by an expert panel, and as a second stage those with one or more areas for concern, or who fail to reply to a second mailing of the questionnaire will be offered a home visit and assessment by a trained health visitor.

Previously unrecognised problems will be brought to the attention of the older persons family practitioner. The results will be used to guide the Board of Health in deciding on the value of more formal screening of the elderly in the Guernsey context.

Patterns of hospital utilisation

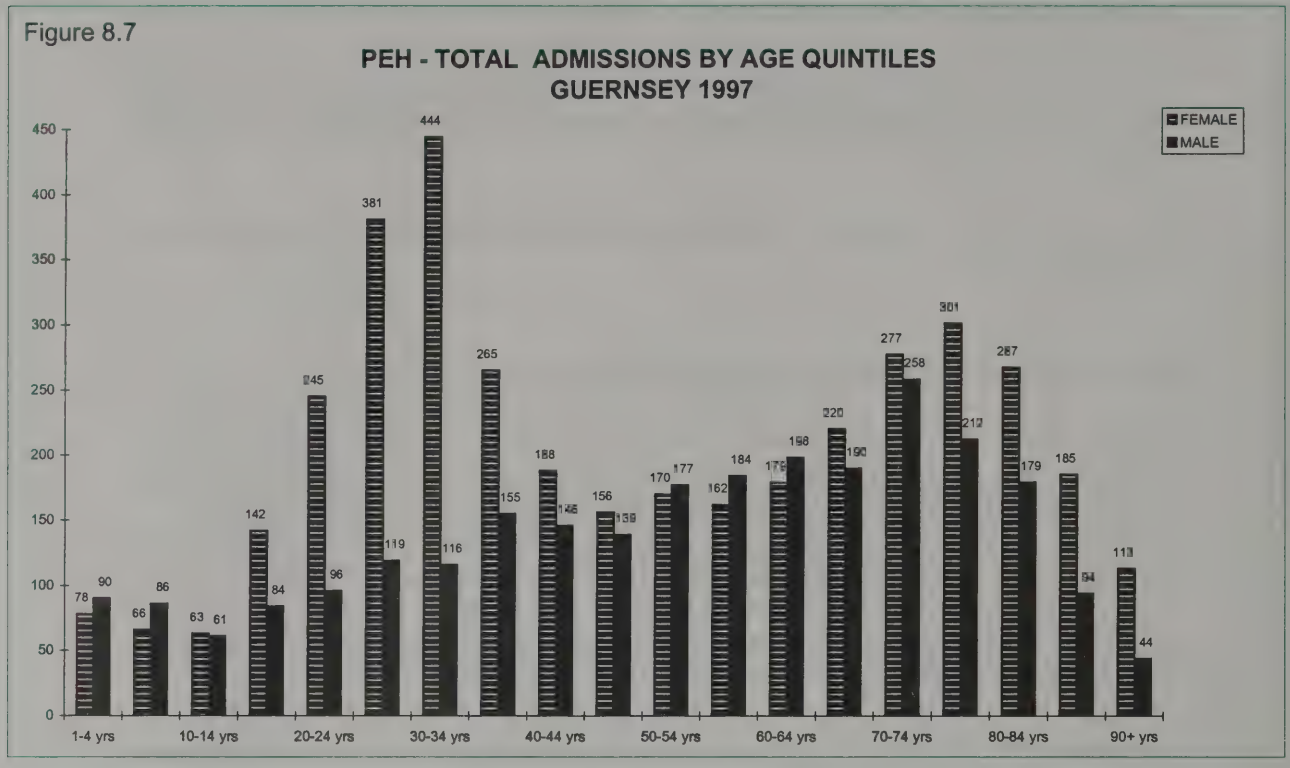
NHS figures suggest that people >65 years:

- Account for 25% of hospital admissions
- Occupy 50% of hospital beds
- Use almost 60% of health and social services budgets

Compared with younger age groups, those > 65 years:

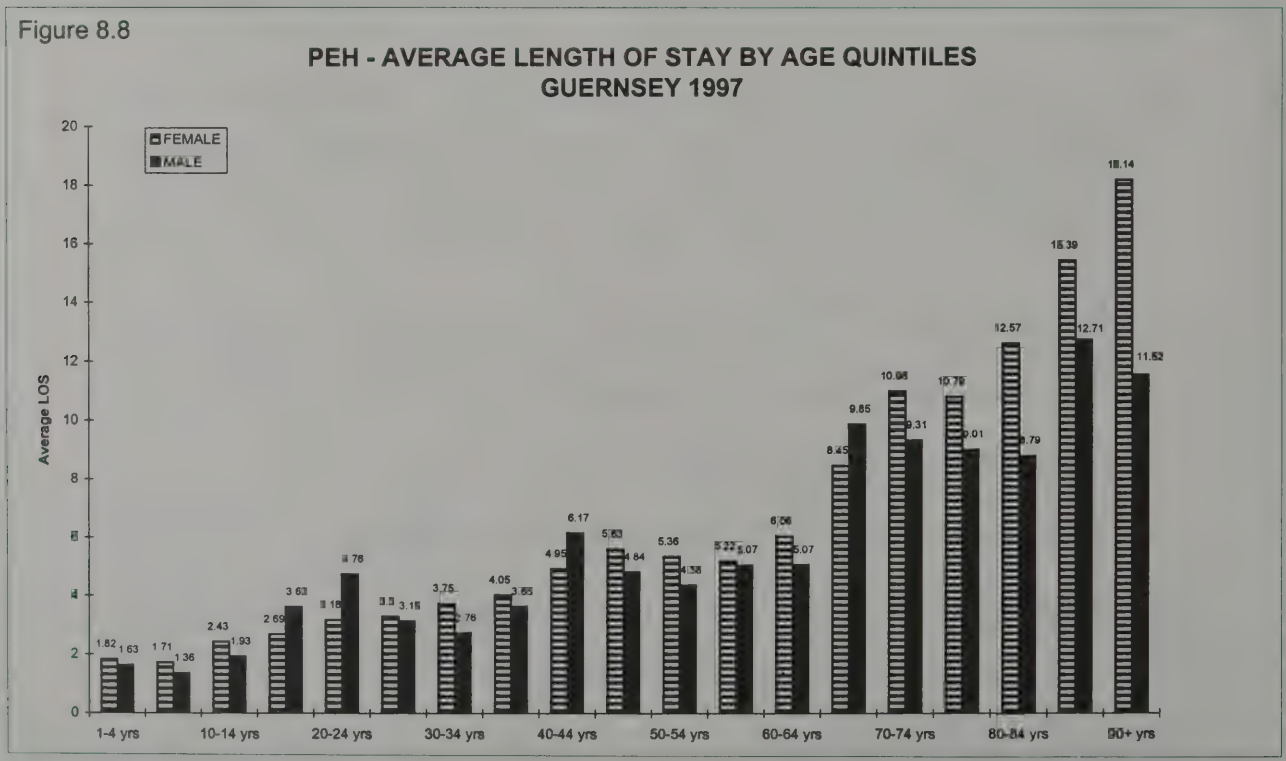
- Are admitted to hospital twice as often
- Stay twice as long
- Visit their GP 50% more
- Visit their dentist 50% less

Figure 8.7



Source: PAS - PEH

Figure 8.8



Source: PAS - PEH

An analysis of admissions to the PEH in 1997 [figures 8.7 - 8.10] show:

- Contrary to expectations, by far the highest numbers of admissions are in the 25-34 age group, and no doubt reflect women entering hospital for child birth, and associated conditions of the reproductive system.

- However, length of stay in this age group is generally short [2.7-3.7 days]. The average length of stay begins rising steadily from the mid 50's [approximately 5 days] to over 12-15 days amongst the 85-89 year olds.

- Combining these two factors, total in-patient bed nights rise from around 2,000 in both the 30-34 age quintiles, to more than 5,000 in the 70-79 year olds.

- These values can be expressed as an odds ratio per thousand resident population in that age quintile. [mean value for all residents = 1.0] Although there are fewer people in older age groups

  - 70-74 years olds twice as likely to enter hospital than the population mean, and will spend over 3 times as long should they require hospitalisation

  - by the time they reach 85-89 years old, although they are only 3.45 times as likely to enter hospital than the general population, they will spend almost 9 times as long as in-patients, with a mean length of stay of 14.5 days.

The range of hospital services provided in Guernsey has developed under historical influences. They may no longer be entirely appropriate for the health needs of the present population, and will need to change further if they are to meet the needs of an ageing population.

There is considerable evidence that a structured approach to rehabilitation following a hospital inpatient episode can allow an older person to return to their own home, rather than needing to enter residential or institutional care. There will obviously be an increasing need for assessment and rehabilitation type facilities as the proportion of older people in our population increases and for doctors and other health professionals with the specialist skills to provide these services.

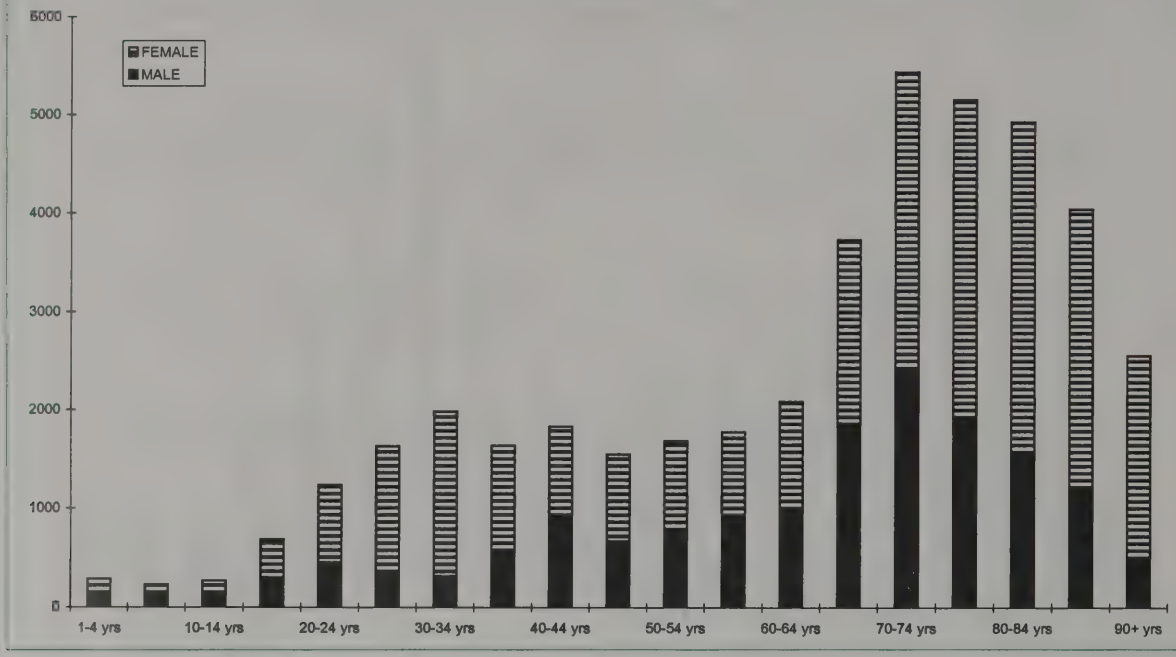
Patterns of illness in old age

Many if not most illnesses and degenerative conditions become more common, and frequently more severe in old age.

Common conditions which may affect the older age group more than younger people include hypertension, stroke, ischaemic heart disease, depressive illness, arthritis, and various cancers including bowel, breast and prostatic cancers. Diseases which are more closely related to old age also include, osteoporosis, increased falls and other accidents, high rates of proximal femoral fracture, confusion, and dementia.

Figure 8.9

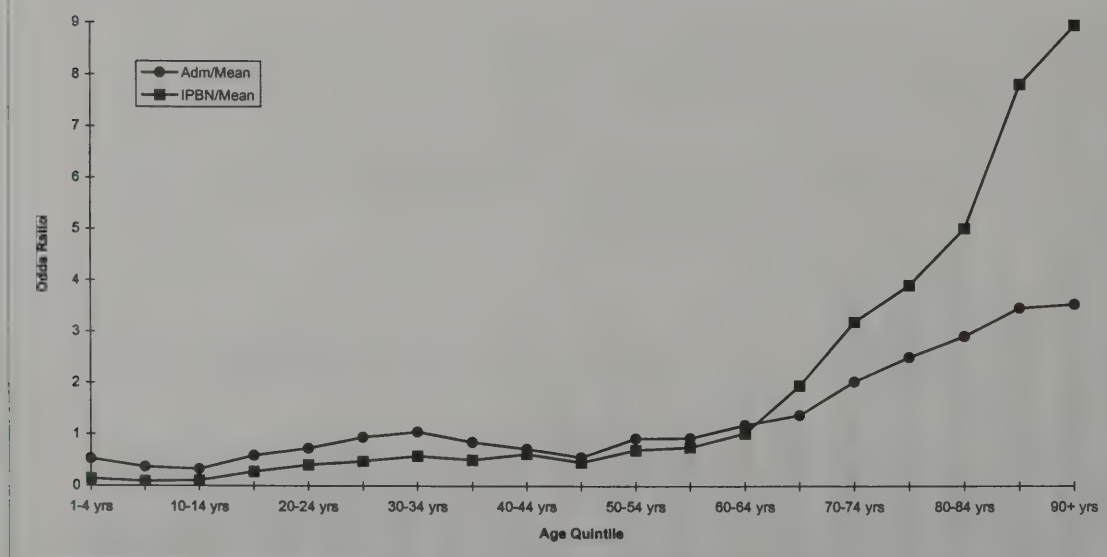
PEH - TOTAL IP BEDNIGHTS BY AGE QUINTILES
GUERNSEY 1997



Source: PAS - PEH

Figure 8.10

PEH - ODDS RATIO FOR INPATIENT ADMISSIONS AND MEAN IPBN BY AGE QUINTILES PER 1000 RESIDENT POPULATION
GUERNSEY 1997



Source: PAS - PEH 1997

Mean Admission Rate = 114/1000 population
Mean In Patient Bed Nights (IPBN) = 733.2/1000 population
Mean Length of Stay (LOS) = 6.53 days

There are also increasing levels of immobility, and sensory loss particularly affecting vision, and hearing. Incontinence can be a frequent and distressing problem, particularly in women.

Opportunities for prevention

However, almost all the above conditions are amenable to preventative measures, or are likely to improved by advances in health technology.

For example, improved diet, appropriate exercise levels, hormone replacement therapy and specific antiosteoporosis treatment can do much to reduce osteoporosis, and the associated risks of hip and vertebral fractures.

Joint replacement surgery is becoming increasingly able to relieve pain and restore joint mobility and with it physical independence.

Although antidementia medication is currently of only limited usefulness, it is likely that new drugs will be developed in this field, which may well slow progression of Alzheimer's disease and other dementias, at least for a period. It is also likely that newer drugs will be able to more effectively treat the depression which so often accompanies ageing and illness in old age.

New technology also has much to offer in counteracting sensory loss. For example, technology is already available linking electronic scanners with voice synthesisers, thus allowing visually impaired people to read printed text.

It is likely that surgical and technological advances will also be able to improve hearing impairment. All evidence is that technological advances will allow older people to remain independent, and often in their own homes for a greater period into old age.

The impact of technology in old age

Speculating on the impact of such technologies on health in older people and on the location of care, a recent review has observed:

'Telemedicine will accelerate the move towards 'hospital at home' in various ways. It will enable current hospital at home procedures to be monitored more closely by specialists, so that those procedures are less dependent on the participation of the patient's GP.

The development of medical equipment which can communicate directly with the hospital will enable new treatments to be carried out at home. This ability to communicate will not only allow the hospital to monitor and adjust treatment regimes from afar but will also enable clinical equipment to be checked serviced and calibrated from the hospital. Tele-district nursing will allow closer monitoring of patients by fewer nurses facilitating more [and earlier] early discharge from hospital'.

'Hospital at home' has been defined as a provision of a service that prevents hospital admission or facilitates early discharge from hospital. Already there is evidence that 'hospital at home' is a safe and acceptable way of delivering care to patients after repair of a fractured femur, which accounts for a high proportion of hospital admissions in the elderly. This is obviously a facet of healthcare which requires further development in Guernsey.

Opportunities for health promotion in the older age group

Health promotion is often seen as something directed primarily at children and young adults. However, as the Health Education Authority [HEA] has commented *'Healthy ageing can be seen as a legitimate goal of health promotion activities irrespective of age. It is an aspect of the benefits conferred by life long health promotion and is relevant therefore to the whole population. If we were to ask what activities or interventions do most to promote healthy ageing we should have to consider the opportunities for health protection across the whole course of a human life - from foetus to very old age - with the goal of healthy ageing in mind'.*

'Maintaining physical, social and mental activity is seen as the key to successful ageing [often referred to as the *'use it or lose it' ethos].* Clearly if it is possible - in the words of the World Health Organisation - to add not only 'years to life' but also 'life to years' then there is considerable potential for the reduction of pain, distress and disability, which are popularly considered to be inevitable accompaniments of old age.

The Centre for Policy on Ageing [CPA] concludes that *'successful ageing is characterised by the preservation of functional ability'* and that *'the dividends that could be yielded by effective health promotion for older people include not only health benefits however. If it is possible to shorten the period of time for which expensive medical services are required or postpone the kind of loss of independence which usually requires long-term nursing or social care then there will be major cost savings, some of which will accrue to older people themselves'.*

When additional resources become available for Health Promotion in Guernsey, activities to promote 'healthy life expectancy' amongst older residents must be a challenging and necessary area to address.

Where will people live?

Chronological ageing is not the same as biological ageing. Only around 10% of all people >65 years in Guernsey self report severe disability at present, whilst the generation reaching older age from 2011 onwards will almost certainly be fitter, more active, and more independent than those in this age bracket today.

It would therefore seem reasonable to predict that the majority of this next generation will not wish to enter institutional care, and that medically this will only be indicated in a minority of cases.

In 1988 the 'Griffiths Report' *'Community Care: Agenda for Action'* suggested that a community care policy should be founded on four main principles:

- People should be maintained in their own homes for as long as possible.
- The level of support required is separable from the issue of accommodation.
- Care should be individually tailored to the needs of each person. Proper assessment needs is essential.
- Care needs to be 'managed' if it is to be provided efficiently and effectively.

Promoting 'community care' in Guernsey

If most older people in Guernsey would wish [and will be medically able] to remain in their own homes for a longer period than in the past, then this will require:

- **Informal carers** [sufficient family, friends, neighbours etc] able to help and assist.
- **Formal 'home help' services** available.
- **Community nursing and health visiting services** structured to community care for some.
- **Supportive and affordable ancillary services, such as** home modifications, occupational therapy, continence service, chiropody, etc, in selected cases.
- **Opportunity to move to 'sheltered housing'** which still allows a degree of independent living, but falls short of full institutional care in due course.
- **Opportunities for access to convalescence/respite care beds** have been shown to delay the need to enter long term care.

Can effective community care be provided in Guernsey?

At present, Guernsey falls short in several aspects from fully meeting these six pre conditions for effective community care. Unless these issues are tackled with some urgency, it is extremely unlikely that Guernsey will have the structures needed to allow people to remain in their own homes for as long as possible, when the time eventually comes.

One obvious shortfall is the availability of voluntary carers. Factors affecting the availability of informal carers now and in the future include:

- Full employment and unsatisfied demand for skilled labour in Guernsey
- High female employment [over 67% of women of working age are now in full or part-time employment]
- A shortfall has been demonstrated in a number of areas at present.
- High cost of living and house purchase means that for many families a second income is essential
- Increased geographical mobility reducing the likelihood of close family members living nearby.
- Smaller families [the 1-2 child family is now the norm]
- Increasing rates of separation, divorce and family break-up

It is likely that these trends will continue in the future, and to exasperate the present shortage of informal carers.

Many of the factors which affect the supply of 'informal carers' also affect the availability of formal care services, such as 'home helps'. Higher wages in some sectors of Guernsey's economy have a 'flow on' effect, and make traditionally low paid occupations such as 'home helps' less attractive. Additionally, the States Manpower Number Limitation policy means there is only limited opportunity for the Board of Health's Community Services to take on the additional numbers of home helps required to meet an increasing future demand.

However, perhaps the biggest constraint towards maintaining a greater number of older people 'at home' in the community is the lack of appropriate housing stock.

Serious shortfall in sheltered housing

Sheltered housing may be defined as:

'A group of dwellings [houses, bungalows, flats, flatlets, or bedsits with shared facilities] intended for older people, and served by a resident or nearby warden, with specific responsibility for that group to enable these persons to live independently through the provision 'on-site on-call assistance'.

The advantages of sheltered housing are said to include:

- Purpose built retirement homes make efficient use of land and building materials.

- Persons moving into sheltered housing usually vacate properties that have become too large for their requirements, thereby freeing accommodation for families to occupy.

- Purpose built sheltered housing promotes and permits a better quality of life for older people, taking away the worry of maintaining a property, so that admission into institutional care can be delayed.

- Elderly people entering sheltered housing generally release capital tied up in their properties, providing them with additional financial resources which reduce the call upon public funds.

- Sheltered housing provided in the same locality enables elderly people to maintain contact with established networks of family and friends. Older people generally value having their own front door' however.

In 1996, the 'Fees Working Party' chaired by the Guernsey Social Security Authority [GSSA] estimated there were around only 170 units of sheltered housing - a rate of 18 units for every 1,000 elderly population in Guernsey.

This contrasts with rates of 46 units per 1,000 elderly population for England as a whole, and 51 units per 1,000 elderly population for South West England [with which Guernsey is more normally compared].

The Board of Health's *'Strategic options for the care of older people'* predicts needs as follows:

Current 'Sheltered Housing' Stock	176	units	[32 SHA]
Predicted need in 2016 @ 50 per 1,000 elderly population	548	units	
Shortfall	372	units	
Less planned new developments			
– Independent sector	31		
– SHA	4		
Revised shortfall	340	units	or approx 20 per year until 2016

It should be stressed that this is a conservative estimate. Likely changes in household size and demand for housing is discussed in the Advisory and Finanace Committee's *'Population and Housing Policies'* Document [July 1998], whilst an independent report suggests that allowing for present unmet need [based on UK provision], that the real shortfall could be some four times greater than this. However 20-25 new units of sheltered housing each year should be an achievable target.

Tackling the shortfall in sheltered housing

It has been suggested that many developers may find it easier to build for first-time home buyers, or more profitable to develop higher priced 'executive homes'. Arguably this may have contributed to the shortfall in sheltered housing in Guernsey in the past.

For the future, not all sites will be equally suitable for sheltered housing. Ideally, sheltered housing should be located on level ground, with easy access to shops and transport links. In order to make it economically viable to employ a warden, at least 20 [and preferably 25] units in one development are desirable.

Because such sites are comparatively rare in Guernsey, there is unlikely to be sufficient development to meet present shortfall and future demand, unless there is some strong positive incentive to encourage such developments. One suggestion is that the Island Development Committee give serious consideration to the creation of a new and separate land use class for sheltered housing development for the elderly.

An impressive example of the innovative thinking that will be required if Guernsey is to increase its stock of 'sheltered housing' over the next 15 years is the recent development of 11 two-bedroomed retirement homes on the 'Les Cotils' site at Cambridge Park. Being located within an existing development, they are able to link in with these facilities, such as use of the cafeteria/coffee bar. Additionally, residents have the security and reassurance of knowing that there is on site help available. There are undoubtedly other sites within the island where similar imaginative approaches are possible. There also may be opportunity to convert existing residential developments into 'sheltered housing'.

The major requirement is that this need is recognised, and that necessary development is facilitated. It is encouraging that this need has already been supported by the Advisory and Finance Committee, who state in their Strategic Corporate Plan [Section 4.6.14] which was adopted by the States in July 1998,

'The States also recognised that there is an underprovision of Sheltered Housing for the elderly in the island, and that to facilitate such accommodation it should be recognised as a specific Use Class. The Island Development Committee will liaise with the Board of Health to identify the site requirements and the extent of provision which should be made for Sheltered Housing in future reviews of the Urban and Rural Area Plans'.

Residential Nursing and Institutional Care

Although 'community care' in a persons own home or in sheltered housing may be the preferred option for many, there will obviously be a proportion of older people who will eventually be unable to maintain a fully independent or semi-independent life because of physical or mental infirmity. A move into residential, nursing home, or institutional [long-term hospital] care has been the traditional solution.

On present estimates, one older person in six [17%] will eventually need more intensive institutional care.

Under the *'Residential Homes Ordnance' 1977* a 'residential home' is defined as *'any establishment the sole or main object of which is, or is held out to be, the provision of accommodation for reward or not, for:*

a) *Persons who are blind, deaf or dumb or other persons who are substantially and permanently handicapped by illness, injury, or congenital deformity; or*
b) *The aged, or*
c) *Both'.*

Under the *'Nursing Home Ordnance' 1977* a 'nursing home' is defined as:

'Any premises used or intended to be used for the reception of, and the providing of nursing for, persons suffering from any sickness, injury or infirmity, and includes a maternity home, and does not include any hospital maintained in whole or in part by the States'.

Many people feel that such a division is artificial, and that such definitions are over rigid. They point out that there are relatively few circumstances in which the combination of 24 hour cover and personal care is genuinely appropriate, and that when increased care for a higher level of dependency does become necessary, most older people would not wish to have to change their place of residence.

The 'single care' home concept

A Royal College of Nursing Report [1992] entitled *'A scandal waiting to happen'* noted that the provision of care takes place in a continuum between providing basic support for living on the one hand, and the need for extensive [and expensive] nursing care on the other. The Report felt that problems result from inappropriate placement of people in residential homes, and from failure to adequately assess and act on the changing health and social needs of residents. The Report concludes that the divide between nursing and residential homes is artificial, and may result in the nursing needs of people in residential houses not being met. Doing away with this difference leads to the concept of a 'single care' home.

The real aim of the 'single care' home concept is to provide a flexible system which ensures that the changing needs of all residents are met, and that standards appropriate to meet these needs can be set, monitored and enforced.

After an extensive period of consultation, the Board of Health sees advantages in the 'single care' home concept, and are therefore considering amending the residential and nursing homes legislation to allow the flexibility required by the 'single care' home concept, whilst at the same time ensuring adequate protection for the needs and rights of elderly and often vulnerable clients.

Whether older people are better off 'at home' or 'in a home' at the moment seems largely a matter of philosophical preference. It is hoped that the results of randomised controlled trials looking at health outcomes in older people who remain at home but with adequate community support, compared with earlier and later admission to long-term and institutional care will be available to guide the development of the appropriate mix of services in this area.

For the time being, all that can be said is that many older people are inappropriately placed at present. For example, an audit performed in 1995 showed only 11% of nursing home residents were defined as fully appropriate for nursing home care, and 54% as possibly appropriate. The rest were probably more suitable for home or residential care. It was estimated that the lifetime costs totalled £42,250 per misplaced resident. The audit also found that 82% of older people entering long term care came from acute hospitals - strengthening the case for adequate assessment and rehabilitation facilities as an essential component of acute hospital discharge procedures for the elderly.

Equally, the only way to ensure that elderly people enter long-term care at an appropriate time is for a uniform multi-disciplinary assessment procedure with in built quality standards. This already occurs in some other countries - in Australia for example, no one enters long-term care without being seen by a geriatric assessment team. It is hoped that such an approach will become an essential and acceptable part of the development of the services for older people in Guernsey, although this may require an increase in doctors and other health professionals with training and skills in this area.

Who should provide long-term care?

At present long-term care [which includes residential homes, nursing homes, and continuing care in hospital] is provided in the State sector by the Housing Authority and the Board of Health, and in the non-governmental sector, by both private [for profit] and independent/ voluntary [not for profit] businesses and organisations.

The imbalance between current provision in these various categories, and the present and future needs of Guernsey, are the subject of extensive analyses in both the discussion document produced by the Fees Working Party [GSSA], and the *'Strategic options for the care of elderly people'* document produced by the Board of Health.

Such analyses suggest that currently Guernsey has an overprovision of hospital beds for the long-term care of the physically frail or confused older people, and also probably an overprovision of residential care beds.

In contrast, there is a shortfall in 'nursing home' type accommodation required by more dependent older people, and a serious shortfall in the sheltered housing necessary to keep people out of institutional care.

The adoption of a 'single care home' concept should go some way to addressing the imbalance between 'nursing beds' and 'residential care' beds, but presupposes enough paid carers can be recruited to provide adequate levels of care.

In order to ensure that the 'single care' home concept truly meets the needs of all its residents, what is meant by 'nursing care' needs to be better defined, there needs to be a competent inspectorate who understand the changing needs of older people, and given the predicted shortfall in nursing staff, there needs to be adequate opportunities for other carers to upgrade their skills through 'NVQ' courses.

Public or private?

Whether long-term care for the elderly should be provided in the public or private sector must be influenced by States policy. This requires that:

- All States Committees need to work within manpower numbers limitation policy.
- There is also a need for most States Committees to work within externally fixed budgets.

Specifically, the 1998 Policy and Resource Planning Billet [Billet d'Etat XIV 98] states .... *'there is a need to review the extent of States activities to determine:'*

- *which services the States could withdraw from having any involvement in without any significant effect on meeting strategic objectives.*
- *Which services could be contracted out to the private sector.*
- *Which services could be provided by fully or semi-dependent agencies;*
- *Within the remaining services, which function may be considered as 'core' [ie specific to government] and which are 'non-core' [ie service to the core functions] in order to review the way the States acquires, maintains, and develops its manpower resources.*

The present mix of facilities in Guernsey can obviously only be altered over time.

However, given the constraints under which the public system must work, and the developing policy of the States that this should concentrate mainly on 'core' activities, then there would obviously be much logic in moving to a position where both public and private sectors each assumed responsibility for undertaking only what they did best.

In practical terms, this would mean that most sheltered housing, and 'care' type accommodation would be provided by private [for profit] and voluntary/independent [not for profit] businesses and agencies, whilst the Board of Health would provide all institutional care for those who required a level of nursing care grant than that which can be provided in the community. It may also be that many of the specialist services provided by the hospital could be provided through the extension of Day Centres and Outpatient facilities at KEVII, without having to maintain expensive long-stay beds.

The major prerequisite for such changes must be for a 'level playing field' with regard to fees between the various accommodation provided by the Board of Health and States Housing Committee, and that provided by the independent and private sectors.

This could be achieved by public sector charging the full economic cost of care, but ensuring that means-tested supplementary benefit be available for the number of older people unable to afford this.

It is hoped that the acceptance of the need for such reforms will be a major outcome of the work of the 'Working Party on the Provision and Funding of Long-term Care'.

Transport links

Guernsey is heavily dependent on the private motor vehicle. 1997 statistics suggest that there are about 36,500 private motor vehicles and a further 3,600 motor cycles for some 60,000 population. Effectively, this equates to almost one motor vehicle for every adult able to drive on the island. The health and social consequences are traffic congestion, traffic pollution, loss of significant areas of the island devoted to parking, and diminished opportunities for other recreational activities such as walking or cycling.
It is inevitable that a proportion of our ageing population will over time become medically unfit [and unsafe] to drive their own motor vehicles. Unless there is an effective system of public transport, they are likely to become increasingly socially isolated, which in turn will have adverse effects of other aspects of their health.

Age Concern have been vocal in their demands for the development of a 'Dial a Ride' scheme in Guernsey for a number of years. More recent developments in technology has led to the successful introduction of the 'computer bus' in a number of European jurisdictions.

This consists essentially of a number of 7-10 seat 'mini buses' equipped with an on board computer linked electronically to a central control. By contacting the central control, it can be arranged for the nearest 'computer bus' to divert to, or close to a persons residence. Their small size makes them able to reach many more locations than are accessible to more conventional/full-size buses. They are said to be close to the convenience of a taxi, and affordability of a bus.

Countries that have introduced them find they are particularly used by, and useful to the elderly and the less affluent. Development of such a system in Guernsey would also have huge benefits in reducing the environmental and social costs of over reliance on the private motor vehicle.

Such a development would obviously form only one component of an overall traffic strategy, but innovative thinking is obviously essential if Guernsey is to provide the necessary internal transport links to meet the needs of an ageing population.

Can Guernsey afford an ageing population?

The additional costs of a greater proportion of older people on the population must include:

- Increased pensions and supplementary benefits
- Increased costs of community services
- Costs of 'sheltered housing' [if provided by the public sector]
- Increased medical costs
- Increased institutional costs

All such costs are at best predictions based on extrapolations of present data. With regard to pensions, the pension fund is reviewed every five years by the Social Security Authority with the backing of the UK Government Actuary.

The last review based on findings for the period 1988-1993 was published in the Billet d'Etat XIII [1996]. During the period, the fund was estimated to have improved its value as a reserve to meet unforeseen contingencies from about $3^1/_2$ to about $4^1/_4$ years expenditure.

Guernsey's pension fund is financed on the 'pay as you go' principle. Old age pensioners accounted for 74% of the funds expenditure in 1993.

On actuarial projections, it was suggested that there needed to be little increase in contributions until 2013, and approximately a 1.5 percentage point increase in contributions by 2033 if benefits were to increase in line with prices.

However, the review pointed out that increasing pensions in line with prices rather than earnings, meant that the living standards of pensioners would not keep up with the rise in living standards of the working population.

For benefits to increase in line with earnings, an approximate 5.5 percentage point increase in contributions would need to be phased in between 1998 and 2033.

Will people vote with their feet?

Guernsey is fairly fortunate in that we have at least 12-15 years 'lead time' before we begin to face the realities of a steadily increasing proportion of older and very old people in our population. We are also fortunate that for the reasons summarised above, the next generation of older Guernsey people is likely to be fitter, more active, and more able to remain independent than persons in this age group in the recent past.

However, in other ways we are poorly prepared for this increase in numbers.

The major issues are less about the costs of providing pensions and other benefits, or even about the costs of community services and medical care - they concern the very real shortfall in adequate 'sheltered housing', and the present lack of appropriate internal transport systems adapted to the needs of an ageing population.

Both housing and traffic are problems which the States have attempted to address for a number of years. However, they both require long-term action, and with regard to the needs of an ageing population, the countdown has already begun.

Guernsey at present must be described as not particularly 'user friendly' to the needs of the elderly. Unless the necessary action occurs within the time available, and assuming that house prices in Guernsey remain more buoyant than in neighbouring jurisdictions, [such as the UK and France], it is possible that a number of older people may be forced to sell up and move to a jurisdiction were they feel that their needs will be better met.

It would be a sad reflection on our values as a community if we failed to take the necessary action to meet the needs of all our population, including the elderly particularly since there appears to be adequate lead time to achieve this.

Thoughts for the future

On the evidence presented, it must be concluded that for Guernsey at least, an increase in the number of older people in the population will not necessarily result in the pandemic of chronic diseases forecast by Kramer in 1980.

More likely, there is some hope that the more optimistic 'compression of morbidity' model is at least a possibility. Certainly, 'Age Concern' in the UK have suggested that 'compression of morbidity' in Britain's ageing population should become a key policy objective of Government.

They further suggest that to extend the period of life which remains disability free would involve a broadbased combination of approaches addressing:

- Physical and social environments [including issues associated with poverty].

- Appropriate health and care services.
- The scope for primary prevention through Health Promotion.

They further add that such a strategy requires that:

- Healthy ageing should be considered from a life-time perspective, as well as in relation to people who are already elderly.
- Promotion and preventive strategies need to be based on research evidence of what works.
- Rehabilitation issues need to be addressed to complement a comprehensive health promotion strategy.
- A realistic strategy, addressing national, local and individual responsibilities needs to be developed, which goes beyond broad aspirations, and addresses the specific actions required to reach desired objectives.

In the years available to Guernsey for planning the best mixture of services to address the health needs of an ageing population, such approaches must be given due and appropriate consideration.

Conclusions - 'Twelve years to get it right!'

This section of the Annual Report has necessarily taken a strongly public health perspective on the measures necessary to meet the needs of an ageing population. From the public health perspective, priorities must include:

- Acceptance that *'people should be able to continue living in a home of their own, whether owned or rented, for as long as possible. This seems best for them, and is what most people in fact want'*. [Board of Health - Principles]
- A further shift of health resources to support 'community care' is required. Such services must also be community orientated, and support unpaid carers, individual volunteers, and voluntary bodies.
- The apparent lack of future carers, both informal and formal remains a potential and largely unresolved problem.
- There is a requirement to invest in appropriate technology to allow people to remain in their own homes for longer.
- More 'sheltered housing' is an urgent requirement. Approximately 20-25 new or converted units per year would go a long way to meeting the present and predicted shortfall. Ensuring such development should be a priority, and the planning mechanism should be used to facilitate such developments.

- The recent support of the Advisory and Finance Committee for this concept is encouraging, and with adequate recognition of the problem, it should be achievable.

- Suitable sites for 'sheltered housing' are likely to be limited. Appropriate incentives may need to be offered to encourage private developers to build 'sheltered housing' for the aged in preference to other development projects.

- A reduction in residential home beds, and an increase in 'single care' accommodation is also logically required. A change in the relevant legislation will be necessary for this to occur, and what is meant by 'single care' accommodation will need to be carefully defined.

- A full assessment by a competent multi-disciplinary team is essential to ensure that people are most appropriately cared for, and this process may need to be repeated in order to cope with their changing health needs.

- It will be important to ensure there are sufficient medical and other health professionals with the training and skills to adequately undertake this role.

- Agreement on measures necessary to achieve a 'level playing field' as regards fees for community and institutional care both the public and private sectors is a hoped for outcome of the deliberations of the 'Fees Working Party'.

- The achievement of 'healthy life expectancy' should be seen as a desirable objective for health promotion.

- Ensuring that an island traffic strategy takes account of the needs of the elderly, perhaps through a 'dial a ride' or 'computer bus' system is also important.

- The most appropriate way to encourage and finance this should be part of an overall island traffic strategy.

- People should only be admitted to a hospital or residential institution when they have needs which can be met in no other way.

Dr David Jeffs
Director of Public Health

August 1998

Chapter 9

Guernsey and Alderney - Vital Statistics

- Births and Birth Related Data
- Deaths and Death Related Data
- Guernsey deaths by ICD-10 Codes and Age Groups 1997
- Alderney Vital Statistics

9.1 Guernsey - Vital Statistics 1997

• Births and Birth Related Data

	Guernsey 1997	Guernsey 5 Year Mean 1989-1993	England & Wales 1996*
Estimated Mid Year	58,946	58,867	51,820,200
Resident Population:			
• Males	28,342	28,297	25,453,100
• Females	30,604	30,570	26,387,100
• M : F	0-93	0-925	0-964
Population Density [Area 63.1Km²]:	934	933	236 (UK)
Marriages:	318	401	291,000
• Marriages/000	5.39	6.81	5.6
Divorces:	175	173	155,500
• Divorces/000	2.96	2.93	3.0
Divorces : Marriages	0.55	0.43	0.53
Births:	672	725.6	653,024
• Males	336	370.8	335,298
• Females	336	354.8	317,726
• M : F	1.1	1.045	1.055
Births outside marriage:	199	148.2	234,088
• % All Births	29.6%	20.4%	35.8%
Stillbirths:	3	4	3,539
• Rate/**000 Live Births**	4.5	5.5	5.4
Early Neonatal deaths:	3	Not separately	3.0
Late Neonatal deaths:	0	calculated	0.9
Infant Deaths:	3	4.2	3,989
• Infant Death Rate/000	4.5	5.7	6.1
Crude Birth Rate/000	11.4	12.3	12.5
Natural Fertility Rate:	52.2	53.3	60.5
Natural Increase per annum:	+0.13%	0.20%	0.16%

***Figures for England and Wales are for 1996, or if not, from the most recent published data.**

9.2 Guernsey - Vital Statistics 1997

• Deaths and Death Related Data

	Guernsey 1997	Guernsey 5 Year Mean 1989-1993	England & Wales 1996
Total Deaths:	593	591	563,007
• Males	291	294	269,828
• Females	302	297	293,182
• M : F	0.96	0.99	0.92
Crude Death Rate:/100	10.1	10.0	10.9
Circulatory Deaths (I00-I99):	218		
• Males	381	417	424
- Rate/00,000			
• Females	379	402	424
- Rate/00,000			
Cancer Deaths (C00-C97/D00-D48):	155		
• Males	321	332	282
- Rate/00,000			
• Females	209	255	251
- Rate/00,000			
Lung Cancer Deaths (C34):	38		
• Males	95.3	101.7	80.2
- Rate/00,000			
• Females	35.9	45.1	42.0
- Rate/00,000			
Breast Cancer Deaths (C50):	6		
• Females	19.6	41.14	47.4
- Rate/00,000			
Alcoholic Liver Disease (K70):	4		
• Males	10.6	12.7	8.5
- Rate/00,000			
• Females	3.3	8.4	5.5
- Rate/00,000			
Injury Deaths (S00-X59):	17		
• Males	21.4	14.1	27.7
- Rate/00,000			
• Females	16.3	9.2	17.6
- Rate/00,000			
Suicide Deaths (X60-X84):	6		
• Males	14.1	9.9	11.0
- Rate/00,000			
• Females	6.5	4.6	3.0
- Rate/00,000			

It should be noted that for most single year data in Guernsey, numbers are extremely small, and should not generally be interpreted to suggest a trend.

9.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS -1997

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Group 1 Infectious and Parastitic Diseases																
A39	Meningoccoal Infection	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0
A41	Other Septicaemia	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
	Total Group I	0	2	0	0	0	1	0	0	0	0	0	1	0	0	0	0
	Group II Neoplasms																
C02	Malignant neoplasm of other and unspecified parts	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
C04	Malignant neoplasm of floor of mouth	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
C05	Malignant neoplasm of palate	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
C15	Malignant neoplasm of oesophagus	5	2	0	0	0	0	0	0	0	0	0	0	3	1	2	1
C16	Malignant neoplasm of stomach	2	1	0	0	0	0	0	0	0	0	1	0	0	1	0	0
C17	Malignant neoplasm of small intestine	1	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0
C18	Malignant neoplasm of colon	10	7	0	0	0	0	0	0	0	0	1	0	5	4	4	3
C20	Carcinoma of the rectum	1	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1
C22	Malignant neoplasm of liver & intrahepatic bile duct	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
C25	Malignant neoplasm of pancreas	2	8	0	0	0	0	0	0	0	0	1	4	0	1	1	3
C26	Malignant neoplasm of other & ill-defined digestive	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
C32	Malignant neoplasm of larynx	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
C34	Malignant neoplasm of bronchus and lung	27	11	0	0	0	0	0	0	0	0	8	6	8	1	11	4
C45	Mesothelioma	1	1	0	0	0	0	0	0	0	1	0	0	1	0	0	0
C50	Malignant neoplasm of breast	0	6	0	0	0	0	0	0	0	1	0	2	0	0	0	3
C51	Malignant neoplasm of vulva	0	2	0	0	0	0	0	0	0	0	0	1	0	1	0	0
C53	Malignant neoplasm of cervix uteri	0	4	0	0	0	0	0	0	0	0	0	2	0	1	0	1
C55	Carcinoma of uterus	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
C56	Carcinoma of the ovary	0	3	0	0	0	0	0	0	0	0	0	3	0	0	0	0
C60	Malignant neoplasm of penis	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
	c/f	53	53	0	0	0	1	0	0	1	2	11	19	20	12	21	19

9.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS -1997

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	b/f	53	53	0	0	0	1	0	0	1	2	11	19	20	12	21	19
C61	Carcinoma of the prostrate	15	0	0	0	0	0	0	0	0	0	2	0	2	0	11	0
C64	Malignant neoplasm of kidney	1	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1
C65	Malignant neoplasm of renal pelvis	2	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0
C67	Malignant neoplasm of bladder	3	3	0	0	0	0	0	0	0	0	0	0	0	0	3	3
C70	Malignant neoplasm of meninges	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
C71	Malignant neoplasm of brain	2	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0
C76	Malignant neoplasm of other & ill-defined sites	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
C77	Secondary & unspecified mal. neoplasm of lymph	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
C79	Secondary malignant neoplasm of other sites	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
C80	Malignant neoplasm without specification of site	3	1	0	0	0	0	0	0	0	0	1	0	1	0	1	1
C83	Diffuse non-Hodgkin's lymphona	2	1	0	0	0	0	0	0	1	0	0	0	1	0	0	1
C85	Other & unspecified types of non-Hodgkin's lympho	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
C90	Multiple myeloma & malignant plasma cell neoplas	2	3	0	0	0	0	0	0	0	0	0	1	2	0	0	2
C92	Myeloid leukaemia	3	0	0	0	0	0	0	0	1	0	0	0	0	0	2	0
C96	Other & unspec malignant neoplasm lymphoid	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
C97X	Malignant neoplasms of independent (primary)	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
	Totals Group II	91	64	0	0	0	1	0	0	3	2	16	20	32	13	40	28
	Group III Diseases of blood & blood-forming organs & certain disorders involving the immune mechanism																
D45	Polycythaemia rubra vera	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
D46	Myelodysplastic syndromes	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
D48	Neoplasm uncert or unknown behaviour other & uns	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
D59	Acquired haemolytic anaemia	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Totals Group III	1	3	0	0	0	0	0	0	0	0	0	0	0	0	1	3

9.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS -1997

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Group IV Endocrine, nutritional & metabolic diseases																
E05	Thyrotoxicosis (hyperthyroidism)	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
E13	Other specified diabetes mellitus	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
E14	Unspecified diabetes mellitus	3	3	0	0	0	0	0	0	0	0	0	0	0	1	3	2
E78	Disorders of lipoprotein metabolism & other lipidae	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
	Totals Group IV	6	3	0	0	0	0	0	0	0	0	1	0	1	1	4	2
	Group V Mental & behavioural disorders																
F00	Dementia in Alzheimer's disease	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
F03	Senile Dementia	3	1	0	0	0	0	0	0	0	0	0	0	0	0	3	1
F10	Mental & behavioural disorders due to alcohol	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
	Totals Group V	4	2	0	0	0	0	0	0	0	0	1	0	0	0	3	2
	Group VI Diseases of the nervous system																
G12	Spinal muscular atrophy & related syndromes	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
G20	Parkinsons disease	4	0	0	0	0	0	0	0	0	0	0	0	1	0	3	0
G30	Alzheimer's disease	0	5	0	0	0	0	0	0	0	0	0	0	0	1	0	4
G31	Other degenerative diseases of nervous system NEC	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
G35X	Multiple sclerosis	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
G40	Epilepsy	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0
	Totals Group VI	6	7	0	1	0	0	0	0	1	0	0	1	1	1	4	4

9.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS -1997

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Group IX Diseases of the circulatory system																
I09	Other rheumatic heart diseases	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
I10	Essential (primary) hypertension	0	2	0	0	0	0	0	0	0	0	0	0	0	2	0	0
I11	Hypertensive heart disease	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
I21	Acute myocardial infarction	19	18	0	0	0	0	0	0	0	0	4	0	3	3	12	15
I23	Certain current complication follow acute myocard	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
I24	Other acute ischaemic heart diseases	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
I25	Chronic ischaemic heart disease	27	27	0	0	0	0	0	0	0	0	0	1	6	1	21	25
I26	Pulmonary embolism	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
I34	Nonrheumatic mitral valve disorders	2	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0
I35	Nonrheumatic aortic valve disorders	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
I39	Endocarditis & heart valve disorders in diseases EC	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
I42	Cardiomyopathy	0	4	0	0	0	0	0	0	0	0	0	1	0	1	0	2
I48	Atrial fibrillation and flutter	1	2	0	0	0	0	0	0	0	0	0	0	0	0	1	2
I50	Heart failure	10	17	0	0	0	0	0	0	2	0	0	0	1	2	7	15
I51	Complications & ill-defined descriptions of heart dis	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
I60	Subarachnoid haemorrhage	1	1	0	0	0	0	0	0	0	0	1	0	0	0	0	1
I61	Intracerebral haemorrhage	2	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0
I63	Cerebral infarction	3	3	0	0	0	0	0	0	0	0	1	0	1	0	1	3
I64	Stroke (or cerebrovascular accident)	9	19	0	0	0	0	0	0	0	0	1	0	0	2	8	17
I66	Oclusion/stenosis cerebral arts not result cerebral inf	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
I67	Other cerebrovascular diseases	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
I70	Atherosclerosis	20	5	0	0	0	0	0	0	0	0	3	0	7	1	10	4
I71	Aortic aneurysm and dissection	4	2	0	0	0	0	0	0	0	0	0	0	1	0	3	2
I73	Other peripheral vascular diseases	3	3	0	0	0	0	0	0	0	0	0	1	0	0	3	2
I74	Arterial embolism and thrombosis	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
I77	Other disorders of arteries and arterioles	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
I80	Phlebitis and thrombophlebitis	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
I82	Other venous embolism and thrombosis	1	2	0	0	0	0	0	0	0	0	0	1	0	0	1	1
	Totals Group IX	108	116	0	0	0	0	0	0	2	0	12	5	21	13	73	98

9.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS -1997

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Group X Diseases of the respiratory system																
J10	Influenza due to identified influenza virus	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
J18	Pneumonia	15	36	0	0	0	0	0	0	0	0	0	1	3	1	12	34
J40X	Bronchitis	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
J42	Chronic bronchitis	4	0	0	0	0	0	0	0	0	0	0	0	1	0	3	0
J43	Emphysema	1	1	0	0	0	0	0	0	0	0	0	0	0	1	1	0
J44	Other chronic obstructive pulmonary disease	13	8	0	0	0	0	0	0	0	0	0	0	2	1	11	7
J46X	Status asthmaticus	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
J47	Respiratory failure	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
J61X	Pneumoconiosis due to asbestos & other mineral	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
J84	Other interstitial pulmonary diseases	1	2	0	0	0	0	0	0	0	0	0	0	1	0	0	2
J90X	Pleural effusion	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
J98	Other respiratory disorders	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Totals Group X	38	51	0	0	0	0	0	0	1	0	1	1	7	3	29	47
	Group XI Diseases of the digestive system																
K25	Gastric ulcer	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
K26	Duodenal ulcer	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
K44	Diaphragmatic hernia	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
K46	Unspecified abdominal hernia	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
K55	Vascular disorders of intestine	1	2	0	0	0	0	0	0	0	0	0	0	0	0	1	2
K56	Paralytic ileus & intestinal obstruction without herni	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
K57	Diverticular disease of intestine	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
K65	Peritonitis	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
K66	Other disorders of peritoneum	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
K70	Alcoholic liver disease	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
K74	Fibrosis and cirrhosis of liver	1	1	0	0	0	0	0	0	0	0	1	1	0	0	0	0
K92	Other diseases of digestive system	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0

9.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS -1997

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Totals Group XI	9	7	0	0	0	0	0	0	0	0	2	1	1	1	6	5
	Group XII Diseases of the skin and subcutaneous tissue																
L93	Lupus erythematosus	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Totals Group XII	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Group XIII Diseases of the musculoskeletal system & connective tissue																
M06	Other rheumatoid arthritis	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
M40	Kyphosis and lordosis	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
M41	Scoliosis	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
	Totals Group XIII	0	3	0	0	0	0	0	0	0	0	0	1	0	0	0	2
	Group XIV Diseases of the genitourinary system																
N11	Chronic tubulo-interstitial nephritis	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
N18	Chronic renal failure	3	4	0	0	0	0	0	0	0	0	0	0	0	0	3	4
N19X	Unspecified renal failure	0	2	0	0	0	0	0	0	0	0	0	0	0	1	0	1
N35	Urethral stricture	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
	Totals Group XIV	4	7	0	0	0	0	0	0	0	0	0	0	0	2	4	5
	Group XVI Certain conditions originating in the perinatal period																
P02	Fetus & newborn affect comps placenta cord	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0
P75X	Meconium ileus	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
P95	Still-born	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0

9.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS -1997

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Totals Group XVI	3	3	3	3	0	0	0	0	0	0	0	0	0	0	0	0
	Group XVIII Symptoms, signs & abnormal clinical & laboratory finding, not elsewhere classified																
R39	Other symptom & sign involving the urinary system	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
R54	Old age (senility)	4	25	0	0	0	0	0	0	0	0	0	0	0	0	4	25
	Total Groups XVIII	5	25	0	0	0	0	0	0	0	0	0	0	0	0	5	25
	Group XIX Injury, poisoning & certain other consequences of external causes																
S02	Fracture of skull and facial bones	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
S72	Fracture of femur	1	2	0	0	0	0	0	0	0	0	0	0	0	0	1	2
T51	Toxic effect of alcohol	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
T68	Hypothermia	1	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1
	Total Groups XIX	3	4	0	0	0	0	0	0	0	0	0	1	1	0	2	3

9.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS -1997

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Group XX External causes, morbidity & mortality																
V23	Motorcycle rider inj'd in coll with car pick-up truck	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
V27	Motorcycle rider inj'd in coll with fixed/stationary	2	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0
W19	Unspecified fall	1	1	0	0	0	0	0	0	0	1	0	0	0	0	1	0
W69	Drowning and submersion while in natural water	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
W70	Drowning and submersion following fall into natural	2	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0
W76	Other accidental hanging and strangulation	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
X44	Acc poison'g/expos to oth & unsp drugs medi & bio	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0
X45	Accidental poisoning by and exposure to alcohol	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
X62	Inten sf pois/expos narcots & psy'dysleptics (halluc)	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
X67	Intent self-poisoning by and expos to other gases	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
X70	Intent self-harm by hanging strangulation & suffocat	2	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0
X71	Intentional self-harm by drowning and submersion	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
X82	Intentional self-harm by crashing of motor vehicle	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0
	Totals Group XX	13	4	0	0	0	0	2	2	4	1	2	1	3	0	2	0
	Total Deaths:	**291**	**302**	**1**	**2**	**0**	**1**	**2**	**2**	**12**	**3**	**32**	**35**	**67**	**34**	**177**	**225**

9.4 Alderney Vital Statistics

	Males	Females	Total 1997	Total 1996
Population (1996 Census):	1024	1117	**2141**	2147
• **M : F**			**0.92**	0.91
Births - In Guernsey:	13	7	**20**	18
- Outside marriage:	3	3	**6**	3
Births - In Alderney:	0	1	**1**	0
Total Births to Alderney Residents:	10	8	**21**	18
Marriages Registered in Alderney:			**9**	7
Deaths Registered in Alderney:	12	15	**27**	27
Natural Increase:*			**-6 [-0.3%]**	

*The natural increase is the difference between the crude birth rate and the death rates expressed as a percentage of the resident population.

10.0 STAFF PROVIDING PUBLIC HEALTH SERVICES 1997

Director of Public Health/Medical Officer of Health
Dr David Jeffs MRCP MFPHM FAFPHM FRACGP FRSH

Personal Assistant
Mrs Maureen Indge [until August 1997]
Mrs Yvonne Kaill [from October 1997]

Data Clerk
Mrs Jenny Elliott [from September 1997]

Part-time Medical Staff:

Deputy Medical Officer of Health
Dr Brian Parkin MB BS BSc MRCP MRCGP DRCOG

Sexual Health Clinic
Dr Nicholas King LRCP MRCS MBBS

Environmental Health Department:

Chief Environmental Health Officer
Mr Michael Bairds MCIEH MRIPHH FRSH

Deputy Chief Environmental Health Officer
Mr John Cook MCIEH

Environmental Health Officers
Mr Stan Horton MCIEH
Mr Tony Rowe MCIEH
Mr Stuart Wiltshire MCIEH
Mr Jonathan Coyde MCIEH

Trainee Waste Regulation Officer
Mr Simon Penney BSc (Hons) Grad M Inst WM

Pest Control Operatives
Mr Paul Tostevin
Mr Michael Brache

Secretary
Mrs Marilyn Bougourd

Health Promotion Unit:

Health Promotion Officer
Miss Yvonne Le Page BEd(Hons) DipHE&HP RHPS

Assistant Health Promotion Officer
Mrs Gerry Grange RGN LAY Trainer RHPS

Resources Officer
Mrs Pat Prevel

Secretary
Mrs Diana Reade
Mrs Pam Marsh [from 3rd March 1998]

Occupational Health:

Clinical Medical Officer
Dr Ian Gee MB BS MRCGP

Occupational Health Nurse
Mrs Pam Smith RGN OHN

Secretary
Mrs Jackie Mallett

Fire, Health and Safety Officer
Mr Mark Guilbert